# The World Health Organisation and the right to health.

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# AND

# THE RIGHT TO HEALTH

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## Abstract

As part of the movement to reform and improve the efficiency of the United Nations generally, the WHO has been subject to a great deal of scrutiny and criticism in recent years. Issues arising from the development of such notions as globalisation of health and global governance in health have added to the pressure for the WHO to establish a clear role that will be effective in the twenty-first century.

This thesis considers whether adoption of an integrated human rights policy, specifically concerned with the right to health, could provide the underlying focus that has so far eluded the WHO. To this end, consideration is given to the current understanding of the concept of the right to health in detail and analysis of the potential impact that adoption of this concept could have on the WHO. Analysis of the structure and legal powers of the WHO is also undertaken to ensure that the organisation is in a position to be an effective advocate and protector of the right to health. Moreover, adoption of a crosscutting approach to the right to health would greatly impact current and future policy and so the potential ramifications are therefore considered in detail.

The main hypothesis of this dissertation is that the WHO would benefit substantially from adoption of the right to health as its underlying crosscutting policy. In addition adoption of this approach would also be important to the conceptualisation of the right to health. Having the WHO as advocate and protector of the right to health would enable the concept to be developed in a positive and supported manner – ensuring it has practical effect.

# Contents

## Abbreviations

| | |
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| ACC | UN Administrative Committee on Co-ordination |
| AIDS | Acquired Immune Deficiency Syndrome |
| ASIL | American Society of International Law |
| CAT | UN Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment |
| CEDAW | UN Convention on the Elimination of All forms of Discrimination Against Women |
| CERD | UN Convention on the Elimination of All Forms of Racial Discrimination |
| CIOMS | Council for International Organisations of Medical Science |
| CRC | UN Convention on the Rights of the Child |
| DESA | UN Department of Economic and Social Affairs |
| D-G | Director-General of the WHO |
| EB | Executive Board of the WHO |
| ECHR | European Convention on Human Rights and Fundamental Freedoms |
| ECJ | European Court of Justice |
| ECOSOC | UN Economic and Social Council |
| EDM | WHO Essential Drugs and Medicines Policy |
| EU | European Union |
| FAO | Food and Agriculture Organisation |
| GA | UN General Assembly |
| GNP | Gross National Product |
| HFA | Health-for-All (strategy of the WHO) |
| HIV | Human Immune Deficiency Virus |
| ICAO | International Civil Aviation Organisation |
| ICCPR | UN International Covenant on Civil and Political Rights |
| ICESCR | UN International Covenant on Economic, Social and Cultural Rights |
| ICJ | International Court of Justice |
| IFAD | International Fund for Agricultural Development |
| IHRR | International Human Rights Reports |
| ILM | International Legal Materials |
| ILO | International Labour Organisation |
| ILR | International Law Reports |
| IMF | International Monetary Fund |
| IMO | International Maritime Organisation |
| NGO | Non-Governmental Organisation |
| OASTS | Organisation of African States Treaty Series |
| OAU | Organisation of African Unity |
| PAHO | Pan American Health Organisation |
| PHC | Primary Health Care (strategy of the WHO) |
| TAC | Treatment Action Campaign |
| UNAIDS | Joint UN Programme on HIV/AIDS |
| UNCTAD | UN Conference on Trade and Development |
| UNDAF | UN Development Assistance Framework |
| UNDCP | UN International Drug Control Programme |
| UNDP | UN Development Programme |
| UNEP | UN Environmental Programme |
| UNESCO | UN Educational, Scientific and Cultural Organisation |
| UNFPA | UN Population Fund |
| UN GOAR | UN General Assembly Official Records |
| UNICEF | UN International Children's Emergency Fund |
| UNIFEM | UN Development Fund for Women |
| UNOPS | UN Office for Project Services |
| UNTS | United Nations Treaty System |
| WHA | World Health Assembly |
| WHO | UN World Health Organisation |
| WHOCO | World Health Organisation's Country Office |
| WFP | World Food Programme |
| WTO | World Trade Organisation |

## Introduction

At present there is an important confluence between the needs of the WHO and the development of the right to health that could have a substantial impact on the future development of international health. Until recently the right to health has been a nebulous concept despite being rooted in numerous human rights treaties. The General Comment on the Right to Health adopted by the Committee on Economic, Social and Cultural Rights in May 2000 was vital in that it finally conceptualised the notion of a right to health as a basic human right and clearly articulated substantive legal obligations that arise from the existence of that right. The General Comment also created an exciting momentum and enthusiasm among bodies concerned with international health issues that needs to be reinforced before it dissipates and the potential energy and focus is lost.

At the same time, the WHO has been under severe pressure to validate its position within the UN system and clarify its role. Its piecemeal approach to health has led to criticisms of ineffectiveness and an inability to address current international health needs. The development and clear articulation of an underlying ethos and philosophy on health as a basic human right would provide the organisation with the essential foundation from which to establish the leadership role in international health that it was originally intended to perform. Embracing a human rights conceptualisation of the right to health could have a dramatic and significant impact on the direction and approach of the WHO to international health. The main hypothesis of this dissertation is that the WHO would benefit substantially from adoption of the right to health as its underlying crosscutting policy and that such an approach would also be equally important to the further conceptualisation of the right to health. Having the WHO as advocate and protector of the right to health would enable the concept to develop in a positive and supported manner and yet remain grounded to ensure it has practical effect.

Human rights have become an important element within the social dialectic. Based as they are in the fundamental dignity of the individual, human rights have been internalised to become a significant part of the social consciousness that seeks to effect social ideals and conditions. Because human rights are derived from the essence of being human the entitlements are available to all without distinction. Health is certainly an indispensable element of life and is therefore pivotal to one's ability to enjoy many of the

other articulated human rights. Therefore, it is essential that health is conceptualised in this manner to emphasise the value and importance of health within society and thereby establishing health as being worthy of protection and promotion.

Certainly the right to health has been enshrined in various international and regional human rights treaties over the years but the definition of the concept has remained controversial and vague. Academics have disagreed on the content and parameters of the right. A right to medical care, a right to health care, a right to the underlying preconditions of health, a right to health protection, a right to health status and a right to human flourishing have all been advocated as the best approach to give effect to the essence of a right to health. However, it is difficult to argue that the right to health is a fundamental human right if it cannot be defined in a legal sense. This confusion and controversy is why the recent general comments of the Committee on the Elimination of Discrimination Against Women and the Committee on Economic, Social and Cultural Rights were so important.

Both committees have provided expansive and detailed outlines of the right to health. The General Comment by the Committee on Economic, Social and Cultural Rights is perhaps the more important of the two because the Committee on the Elimination of Discrimination Against Women has a much narrower ambit and therefore any definition arising in relation to that treaty will reflect these narrower parameters. The Committee on Economic, Social and Cultural Rights was particularly important in identifying legal obligations and duties on states as states have the main responsibility for the health status of their people. Three types or levels of obligations were identified in relation to the obligations on State parties. They are: the obligations to respect the need for health, the obligation to protect health and the obligation to fulfil the right to health. The Committee identifies a minimal level of core obligations in relation to the right to health and a second set of obligations of 'comparable priority'. It also identifies specific acts or omissions that are violations of the right to health. The result is an expansive and detailed outline of the right to health that goes beyond a literal interpretation of Article 12 of the ICESCR.

However, as essential a beginning as the General Comment was, it is not the end. While the General Comment has gone a long way to conceptualising the right to health it has limitations. Some integral definitions and concepts remain vague, the globalisation of health needs to be addressed in detail, the role

of non-state actors needs to be developed further, and normative standards need to be developed to detail specific obligations in relation to the right to health. The further development of the right to health in this way, however, is not only beyond the mandate of the Committee on Economic, Social and Cultural Rights but beyond its resources and technical expertise. The General Comment on the Right to Health has certainly established a clear framework for the right but without further interaction between human rights experts and health professionals it is difficult to envisage the further development of the right to health so as to ensure it has the broadest practical impact.

The WHO would seem to be the obvious choice to take on this role. It could adopt the right to health as its raison d'être so as to build on the General Comment to develop the concept beyond the confines of a specific treaty provision. It has the constitutional mandate to adopt such a position and as a specialised agency of the United Nations, it even has certain legal obligations in relation to human rights. Yet to date, the WHO has been reluctant to recognise the right to health. It has preferred to adopt a medical, ad hoc and pragmatic approach to health. This is not to negate the important role the WHO has had in the development of international health policy over the years. Its achievements include the eradication of smallpox, improvement in polio control, development of simple and effective methods of managing diarrhoeal diseases, development of the Codex Alimintarius and instigation of the International Code of Marketing of Breast-Milk Substitutes. Moreover, since its inception in 1978, Health-for-All has been one of the WHO's dominant programmes and is concerned with ensuring universal access to a minimum level of health care. In fact, the work that the WHO has done in relation to its Health-for-All programme has clearly influenced the development of the right to health even though the approach was developed without any consideration of human rights. Indeed, there is clearly a great deal of overlap between the Health-for-All approach to health and the right to health as articulated by the Committee on Economic, Social and Cultural Rights.

Despite these achievements, it has become clear that the WHO is struggling to meet the needs of the global community in health. Its isolationist approach to international health has led to serious problems in terms of communication and co-ordination of policy with other UN agencies who have gradually expanded their original mandates to address health issues. This has resulted in confusion and overlap of policies and has led to proposals for reform of the WHO that range from fine tuning the existing institutional mechanisms and management practices of the WHO to its abolition on the grounds that it is now obsolete. As a

practical matter, the WHO has two main limitations on its ability to adapt to the changing needs of international health. Firstly, the organisation is too dependent on the personality of the Director-General to provide direction, motivation and develop policy. While this may have led to the WHO adopting a dynamic approach to health in its early years it has also led to long periods of stagnation. The second problem for the WHO is that the objective of the organisation, as established in its constitution, is too broad to provide a clear mandate. As a result, the WHO needs to develop an underlying philosophy to provide coherence and direction. Adoption and development of the right to health would provide the WHO with a clear mandate based on a normative human rights framework. By so doing, it would also provide a measure of external accountability. There is the opportunity for the right to health and the WHO to move forward together. But more than that, there is an interdependency between development of the right to health and the continued effective functioning of the WHO in international health that needs to be recognised, acknowledged and acted upon now.

Fortunately, the WHO has a decentralised structure that would facilitate adoption of a right to health approach. However, the effectiveness and efficiency of the regional structure would need to be improved to ensure a flow of information between local communities, states, regions and central headquarters. While there would be no need to make any constitutional amendments, it may be necessary to reform the existing structure to better facilitate the adoption of the right to health approach. In particular, it may be appropriate to establish a permanent 'Academy of Health' or similar body to facilitate development of the concept of a right to health.

The WHO also has the power to draft and adopt treaties, regulations and recommendations. Although in the past these powers have been under-utilised, in the longer term, they would have an important role in the development of this human rights approach to the right to health. Facilitating the drafting and adoption of a Framework Convention on the Right to Health would serve to galvanise the broader international community to focus attention on the right to health. The aim would be to establish a Framework Convention that could build on the legal obligations as defined in the General Comment on the Right to Health adopted by the Committee on Economic, Social and Cultural Rights to broaden and consolidate the range of legal obligation arising from the right to health. The consultation process, necessary to develop the framework, would also facilitate a dialogue between states and other non-state actors such as human

rights treaty bodies, NGOs concerned with human rights and/or health, grassroots advocacy groups, international organisations and multinational organisations.

Before it is possible to embark on the process of drafting a Framework Convention to promote and protect the right to health, some basic issues need to be addressed that have already been raised by the General Comment. The development of indicators and benchmarks to monitor action taken to meet obligations arising from the right to health is an essential first step. Similarly, a model is needed to assess the impact of policy on the health of individuals or communities. Without a health impact assessment system it is difficult to ensure that international policy is not going to have a detrimental effect on the health of those that the policy is seeking to assist. As the right to health is concerned with protecting and promoting the health status and human flourishing of individuals, it is also important to ensure that the development of the right to health reflects the needs of the individual and local communities. To ensure that this occurs, a process of consultation needs to be instigated and a system of continual dialogue needs to be developed that enables the flow of information and ideas to and from the international level, to the region, state, local community and individuals. The WHO has shown that it has the capacity to develop such a dialogue as it utilised such an approach prior to the drafting and adoption of the World Health Declaration in 1998. In partnership with human rights treaty bodies and other interested parties, the WHO also has the experience and technical expertise to develop human rights indicators as well as a model for health impact assessments. If the WHO were to adopt the right to health as its underlying philosophy it would, in effect, be taking on the responsibility to develop these programmes.

As well as having to develop new programmes, adoption of the right to health would also require the organisation to develop a crosscutting focus to ensure that all WHO policy was grounded in human rights principles. For example, policy concerned with the eradication TB would have to ensure that the individual's human rights were not been violated in the process. The approach adopted in relation to prevention and control of HIV/AIDS has shown that this is not only feasible but results are improved if the dignity of the individual is respected.

Given the WHO's technical expertise, the WHO is also ideally able to play an essential role through the collection, analysis and dissemination of information that can provide evidence of health trends and their

association with the respect for or neglect of human rights. To this end, however, the WHO would have to be prepared to develop a more analytical and critical approach to data than it has been willing to do in the past.

The adoption of a human rights approach could also benefit the external relations of the WHO. Having a common language and focus allows for improved communication and co-ordination with key partners in international health. Confrontation with these key partners would be avoided if a system were developed to ensure early consideration is given to assessment of policy based on the right to health.

Finally, advocacy of the right to health would provide a leadership role for the WHO in international health. The protection of the right would vest the WHO with greater moral and legal authority than it currently has particularly in its relations with such organisations as the World Bank.

The right to health has frequently been dismissed as a concept too vague to have practical utility. The first part of this thesis establishes a clear understanding of the right to health. It also shows how the right to health has the potential to address issues arising from the social impact of the rapid globalisation of health. Firstly, the obligations arising from a human rights approach to the right to health need to be established. To this end, chapter 1 considers the concept of human rights, its influence and practical social effect before considering its potential impact on health. Chapter 2 analyses the various treaty provisions that establish the right to health as having legal effect and the subsequent attempts by publicists and UN conferences to define these obligations. As noted above, the legal obligations established in relation to the right to health have been vague and controversial until the adoption of the General Comment on the Right to Health by the Committee on Economic, Social and Cultural Rights. Therefore, the legal obligations contained in the General Comment are considered in detail in chapter 3. The General Comment on the Right to Health was an important beginning because it authoritatively conceptualised the right and established specific legal obligations but it also has limitations. The limitations of the current system are also considered and the proposal is made that a broader based human rights approach to the right to health may be more appropriate to meet the concerns associated with globalisation in health and global governance in health.

With increasing pressure on UN organisations to integrate human rights into their activities and the need for the WHO to establish its role in the globalisation of health, this thesis considers the important role the WHO could have in protecting, promoting and developing the concept of the right to health as well as the beneficial impact the right to health could have on the WHO. The WHO also has a broad constitutional mandate of its own to promote the right to health. Chapter 4 details this mandate, analyses its current role in international health and its work to date in relation to the right to health. Chapter 5 highlights the essential symbiotic relationship between the right to health and the WHO and considers how both could reach their full potential as partners. The next chapters consider how feasible it would be for the WHO to adopt the right to health in this manner by, in chapter 6, examining the existing structure and considering possible reform options that would enhance the WHO's ability to give effect to the right to health in the longer term. Chapter 7 determines how the legal powers of the WHO have been utilised so far and considers their potential use in promoting the right to health. Chapter 8 considers the potential impact that such a crosscutting approach to the right to health would effect current and future WHO policy. As possible advocate and protector of the right to health, it is also important to consider the potential impact on the

WHO's external relations. One way to consolidate broader legal obligations under the right would be for the WHO to instigate the drafting and adoption of a Framework Convention on the Right to Health. Therefore, as part of my long-term strategy, I detail the possible format and content of such a treaty. The findings of this thesis are summarised in Chapter 9 in the form of a list of recommendations to the WHO that are necessary to effectively incorporate the right to health as its underlying philosophy and basis of action as well as action necessary to develop the right to health to fulfil its full potential.

Finally, I also reach some conclusions as to the impact this approach could have on the development of international health. My main conclusion is that there is an essential interconnection between the right to health and the WHO: only together are both likely to reach their full potential.

# 1.
# The impact of human rights

Making the right to health a part of the human rights agenda would dramatically highlight the fundamental importance of health in society and thereby establish it as being worthy of protection and promotion. In this way, the right to health also looses its aura of being beyond the realm of human influence. Inherent in the concept of a right to health is the notion of human rights itself and the standing that the system of human rights has in modern society. This chapter sets out the concept of human rights and the effect of a right being a human right as a precursor to the consideration of the right to health as a human right.

## A. What is a human right?

The modern concept of 'human rights' is an attempt to define fundamental characteristics that establish the essential elements of human wellbeing.[1] On a global scale, the Universal Declaration of Human Rights of 1948 was such an attempt, reflecting the social priorities of its time. There continues to be substantial controversy in moral and political philosophy as to the justification of rights, the true nature and content of rights and the inter-relationship of rights with other moral concepts.[2] While there is a wide range of academic material that has sought to examine the justification of rights from various jurisprudential positions, to date there is no consensus as to the origin of the legitimacy that underpins them. However, whether one examines this question from the perspective of a naturalist,[3] positivist,[4] Gewirthian,[5] Rawlian,[6] or a communitarian,[7] it is irrefutable that these rights exist and have an important role in modern society.

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[1] Mann, J. (1996): 'Health and human rights'. Vol.312 British medical journal, pp.924-925 at p.924. Despite being a non-lawyer, Mann was such a seminal figure in health and human rights that his perspective is of sufficient import.

[2] Brock, D. (1994): 'The President's Commission on the right to health care' in Health care reform: a human rights approach, Chapman, A. (ed.) at p.72.
Unfortunately, in this thesis, it is not possible to examine all these ideas in detail but a comprehensive precis can be found in Fuenzalida-Puelma, L. and Connor, S. (eds.) (1989): Right to health in the Americas: a comparative constitutional study.

[3] For examples of this theory see: Fuller, L. (1969): The morality of law.
or Finnis, J. (1980): Natural law and natural rights.

[4] For examples of this theory see: Hart, H. (1961): The concept of law.
or Raz, J. (1980): The concept of a legal system.

[5] Gewirth, A. (1996): The community of rights.

[6] Rawls, J. (1971): A theory of justice.
or Rawls, J. (1993): Political liberalism.

[7] Allott, P. (1990): Eunomia.

Dupuy argued that fundamental human rights should be considered as a 'common heritage of mankind' or a component of human social evolution applicable to all.[8]

> "Consequently, since human rights are a common heritage of mankind, it means, that everybody is entitled to invoke them. They are valid *erga omnes*, and all men are entitled to shout when human rights are flouted."[9]

It is **this** potential empowerment of individuals in relation to other domestic and international institutions that is exciting and differentiates human rights from other possible mechanisms. Human rights are not just a legal concept. Indeed, the confusion and frustration experienced with human rights often lies in the failure to distinguish moral obligations and duties from legal ones. I believe that fundamental rights are not earned but are entitlements due to the individual simply by virtue of being human. As such, they should be valued and protected by society utilising all available mechanisms. In short, **human rights should be considered as the minimum rights necessary for a life of dignity and be discernible by virtue of a belief in our underlying common humanity.**[10]

As a practical matter, the definition of each human right is both general and broad. This does not mean that clarification of human rights is impossible but takes into account the fact that any definition of a human right is determined only in relation to the values and ideals of society at that particular point in time. While accepting that any attempt to define human rights is limited in this way, it is clear that the current concept has certain inherent, core characteristics that are inalienable and even natural.[11] For example: equality, non-discrimination and protection of the vulnerable.

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[8] Dupuy, R. (1979): 'Conclusion of workshop' in The right to health as a human right at p.483.
[9] Ibid.
Certainly Judge Weeramantry in his discussion of Article 12 of ICESCR considered that this was reinforcement of the obligation *erga omnes* towards the entire global population.
[In his dissenting opinion for: *Legality of the Use by a State of Nuclear Weapons in Armed Conflict*, advisory opinion, 1996 ICJ Reports, p31, 2b.]
[10] Leary, V. (1993): 'Implications of a right to health' in Mahoney, K. amd Mahoney, P. (eds.) Human rights in the twenty first century : a global challenge at p.483, quoting Tom Campbell.
[11] The argument that human rights are *erga omnes* and yet also historical and context-dependent would seem to be contradictory but as Mullerson argues in his book these views can be reconciled. Human rights are not immutable but rather develop and change but the core (though not eternal and immutable) has become in the contemporary world inalienable and even natural.
[Mullerson, R. (1997): Human rights diplomacy].

While acknowledging that it also has a wider moral and social dimension, the notion of human rights has become rooted in the rule of law.[12] As a result, essential elements of human rights, such as non-discrimination and equal treatment of each individual, are not only considered moral imperatives but have also become an integral feature of modern legal systems. This integration into the rule of law has been empowering for the individual because it ensures recognition of personal dignity and respect and encourages a system that promotes individual freedom and social co-operation.[13]

In the end, human rights are special in that they assert the commonality of human kind by establishing a global framework for all law making without transcending the values of a given society or the plurality of values that together form the international community and promote a common good.[14] It has provided the tools to enable individuals to participate in the social struggle for power within a system established by states. States and the international organisations or institutions they formed have become locked in a powerful dialectic.[15] While the concept of human rights has provided a voice for the individual within a given society, this can only be achieved in accordance with the prescribed power structure. For Yamin, "[r]ights therefore suggest, if not encode, certain definite conceptions of power, agency, causality and responsibility". This does not, however, preclude the possibility of change; instead it channels energy into a particular mode enabling a 'controlled' or 'structured' revolution. (A feature certainly not envisaged by the states that ratified those early human rights treaties.) What is at stake constantly in this process is the relationship between the international community, the state and the individual.

[12] At the international level one immediately thinks of the Universal Declaration of Human Rights, 1948, the ICCPR, and the ICESCR as well as the plethora of United Nations human rights treaties inspired by these basic treaties.

[13] While the individual does not normally have standing within the international system exceptions have been made under the optional protocols of the ICCPR, CAT and CEDAW, to strengthen individual rights. Similar rights are to be found in various regional treaties such as the European Convention of Human Rights and the Inter-American system. These international systems have impacted on the domestic legal system as a result both of constitutional changes it has inspired and because of the need to re-assess policy decisions to accord with rulings from bodies established under the human rights treaty system.

[14] Allott, (1990), p.286-7, 15.63.

**B. The power of human rights**

"[T]he very existence of universal human rights is a proof of a certain, albeit rather weak, unity of mankind."[16] The extension of individual interest from the personal to the global has been important for internationalising issues and establishing international organisations. Modern technology in communications and travel has broadened the outlook of individuals. Communities also have a greater interdependence so it is understandable that individuals, local communities, states and the international community as a whole are concerned with human rights issues wherever they arise.[17] This interest has become a powerful tool to moderate the actions of states already voluntarily restrained by the establishment of an international treaty system of human rights.[18] Certain constraints have been placed on the powers vested in the state with corresponding protection for the freedom of the individual. Positive duties have also been imposed on the state, but these are only to be promoted within the confines of social resources and do not necessarily ensure individual entitlement.[19]

The concept of human rights both empowers the individual and weakens the state's power. Yamin argues that "[w]hat are labelled as rights are really those building blocks of dignity, those tools that allow one to decide what the meaning of one's life will be". This argument suggests that human rights have a dominant impact on the life of the individual. While some may argue that this position is extreme, it is clear that the emphasis on equality; non-discrimination; entitlement; and civil, political and social justice has a considerable impact on many people. The fact that the concept of human rights is not based on a system of desert or cost-benefit analysis strengthens its impact even further.[20]

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[15] The legitimacy of the 'nation state' is bound up in the protection of its citizens and the constitution. To deny the rights enshrined in these constitutions and the international declarations of similar rights, to which they have consented, would be to bring into question the very fabric of their power.

[16] Mullerson (1997), p.159.

[17] Ibid.

[18] Ibid.

> "Indeed, from the point of view of morality, and also that of common sense, it seems to be not only possible but also necessary to argue that, if there are international standards of human rights, then reaction to the violation of these standards cannot be interference in either the internal or external affairs of the states where violations take place."

[19] Even in circumstances when the concept of individual 'entitlement' to a right is controversial, there still remains the right to be considered for the utilisation of any resources considered appropriate to their needs.

> "...[C]harters lay down the duty of a State to abstain from actions harmful to health seen from a negative point of view, but also to extend benefits from an egalitarian point of view, through a kind of equalisation of suffering and recovery."

Dupuy (1979), p.483.

[20] O'Keeffe, J. (1994): 'The right to health care and health care reform' in Chapman, A. (ed.): Health care reform: a human rights approach, at p.77.

It should also be remembered that human rights terminology has become part of modern social vocabulary and is not confined to a particular technical definition.[21] This internalisation of rights has highlighted manifest inequality by the simple use of comparison.

> "...[The] deprivation of any rights is a manifestation of the creation of a class of *others*, and deprivation is heinous particularly when comparison is made with those who are not affected or deprived. If there were no deprivation, there would be no *otherness*."[22]

This ability to compare has been important in uncovering certain social myths. It has been possible to show that many limitations on human life are social creations and are not omnipotent. Human rights, therefore, empower individuals or groups to feel that there is the possibility of change but only if there is the social will and cohesion to make it happen. The social determinant dialectic is the perpetual process of change and evolution by which society responds to the past and future to determine its standards and values. Human rights are part of this process because they enable social participation and encourage critical evaluation of the past and therefore become part of the social consciousness that makes the future out of the past.

> "Evaluations do not appear from nowhere; they are formed in social settings. People within the same culture will tend to make the same basic evaluations concerning the good life from a welfare point of view. This will in most cases result in a great deal of intersubjectivity in judgement."[23]

So that the social consciousness while continually reinterpreting and re-evaluating does so from a firm position rooted in culture, traditions, religion, history, science, economy, morality and law.

The banner of human rights can channel public support towards peaceful reform.[24] Individual's and group's participation in issues affecting them is an essential aspect of human rights,[25] but this agenda has yet to received much attention at the international level.[26] According to Campbell, by providing a comparative tool,

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[21] Leary, V., Connor, S., Lillich, R. & Lutz,E. (1988) : 'Health, human rights and international law: a panel'. Vol.82 American society of international law proceedings, pp.122-141, at p.123

[22] Alleyne, G. (1997): 'Health and human rights: the equity issue.' Vol2 No.3, Health and human rights, pp.65-70, at p.69.

[23] Nordenfelt, L. (1987): On the nature of health: an action-theoretic approach, p.80.

[24] This is not to deny that there may be clashes with public authority, but if all parties respect the concept of rights then generally the demonstration should be peaceful.

[25] Leary, V. (1994): 'The right to health in international law'. Vol. 1 (1) Health and human rights, pp.24-57, at pp.35-36.

[26] Any grassroots movements that have developed have often been considered subversive by existing state authorities. One obvious exception to this is, of course, the WHO's policy on Health-for-All as discussed in Chapter 4.

> "[h]uman rights discourse then serves both as a potent source of radical critiques of actual social arrangements and also as a powerful basis for working out and presenting alternative institutional practices."[27]

It also has the potential to facilitate measured discourse within a given society. By establishing and continually evaluating social and political priorities, a society is able to evolve positively and peacefully. In effect, human rights have the potential to be a radical tool, enabling the transfer of power within a given society by demanding that consideration be given to alternative institutions of power.

**C. The enforcement of human rights**

The existence of a right implies there must also be a corresponding duty or obligation. Before any right can be enforced it has to be clearly defined and the focus of the obligation must be ascertainable. Because of the close link between moral rights and legal rights, a sense of obligation can exist within the social fabric but outside the law. The power or influence of such rights, however, is not negated merely because it is unenforceable.[28] A right may be so deep-rooted in the value-system of society that it is sufficiently protected by social norms or proprieties. Public pressure, lobby groups and media coverage can, on occasions, provide an informal but effective monitoring and enforcement system. This was highlighted by the court case between 39 Pharmaceutical Firms and the South African Government.

> "Important victories in the fight for access to treatment have occurred in the last week. The Treatment Action Campaign (TAC) was admitted as a friend of the court (amicus curiae) on 6 March in the much publicised case between multinational pharmaceutical companies and the South African Government. In addition, the international day of action called by TAC for 5 March was a resounding success. Around the world people mobilised demanding that the drug companies withdraw their legal action. The media gave full coverage and the court case captured headlines in most major newspapers and news broadcasts. Around the world, people hold the multinational pharmaceutical industry responsible for a large share of the blame for millions of unnecessary deaths. As a result of this pressure, drug company, Merck, announced a substantial drop in the price of its two anti-retroviral medicines. Furthermore, the Pfizer donation to the

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[27] In an introduction to a collection of essays entitled Human rights from rhetoric to reality, as quoted by Leary, op.cit., p.123.

[28] Some rights are considered not to warrant coercive enforcement.
A right "...should not be disqualified as a right simply because it is a progressive right, or because no court can really decide the exact content, or because no coercive enforcement mechanism currently exists or is likely to exist. But these aspects do affect both the expression and use of the right as well as our understanding of law and rights."
Jamar, S. (1994): 'The international human right to health'. Vol.22 (1) Southern University law review, pp.1-68, at p.16.
C. Scott and P. Macklem in their article also argue that justiciability is a 'fluid concept' that may evolve over time.
[(1992): Constitutional ropes of sand or justiciable guarantees? Social rights in a New South African Constitution. Vol.141, No.1, University of Pennsylvania law review, pp.1-147]

> South African government, with all the problems accompanying it, has finally come through. This was a direct result of activist pressure."[29]

This result occurred despite the fact that the pharmaceutical companies had a strong legal case. As TAC admitted: "[i]t is by no means a formality that the government will win".[30] On other occasions, the simple initiation of dialogue, because there is a common language through which to communicate, can in itself be sufficient to effect change. Having a common language through which to express concerns ensures a better understanding of the issues, thereby making effective accommodation more likely. Political pressure alone, at domestic and international levels, has also been shown to have an important impact on the activities of regions, states, communities and individuals.[31]

Most of the human rights treaties place the rights with individuals or social groups and the duties and obligations on the state. These duties and obligations on the state can be divided into three categories: to **respect** rights by not violating them, to **protect** rights by monitoring and taking positive action against third party violators, and to **fulfil** rights by employing governmental means to afford individuals the full benefit of human rights.[32] Various mechanisms, at international, regional and domestic levels, have been established to try to ensure that states comply with their treaty obligations.[33]

Because the rights are vested in the individual, it is the individual who is interested in protecting and maintaining these rights. Even though the individual or group of individuals officially has only limited standing in public international law, they remain the most effective monitoring system.[34] Remedies are normally available to an individual in domestic law for legal damages; whether this is also true for a

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[29] Treatment Action Campaign, (2001): South Africa and access to pharmaceutical drugs: friends of the court: questions and answers. http://www.tac.org.za/ns010313.txt, p.1 downloaded June 2001.
[30] Ibid, p.2.
[31] Within the UN system this can be reinforced by legal sanctions especially if the UN Security Council deem the situation a threat to peace and security (UN Charter, 1945, Articles 39, 31 and 42).
[32] Shue, H. [(1980): Basic rights, subsistence, affluence and U.S. foreign policy]; and Eide, A. [(1987): The new international economic order and the promotion of human rights. UN Doc. E/CN.4/Sub.2/1987/23, 7 July 1987.] were the first to develop this tri-partite typology of state obligation.
[33] For details see: Merrills, J. (3rd ed.) (1989): Human rights in the world; and
Cook, R. (1998): 'State accountability for women's health' in Health legislation at the dawn of the XXIst century. Vol.49, No.1 International digest of health legislation, pp.264-282.
[34] The Human Rights Committee, the Committee against Torture and the Committee on the Elimination of All Forms of Discrimination against Women have limited power to hear petitions by individuals with grievances against the conduct of a particular state. Even here the decision of the committee is in the form of a recommendation and as such cannot be considered binding on the state concerned. Generally, however, states are reluctant to be seen to ignore such judgements and therefore prefer to comply with the committee's findings.

violation of their human rights is dependent on the domestic constitution. At the international level, the focus of protection is directed more towards prevention or deterrence. How effective this protection is in practice can only be determined by the vigilance of individuals or groups and careful monitoring by international bodies or non-governmental organisations. At the moment, international and domestic non-governmental organisations are in a much better position to collect data and evidence at grassroots level that can be used in support of claims of human rights abuse or failure by the state to meet its obligations. Even though organisations such as the WHO collect a great deal of relevant statistical and epidemiological data, they currently do not analyse or present the data in a way that is always useful from a human rights perspective.[35]

It is essential that all elements of society have a voice within the system to ensure protection of their rights. Public participation is an important element of this protection as it becomes part of the movement to continually re-assess the needs and values of society that underpin the human rights system. Existing non-governmental organisations have an important role but should not be relied on to act as the sole voice of society because they often have a specific, narrow agenda. International institutions need to develop their own structured dialogue that reaches below regional or state level to gain feedback at the grassroots.

While it can be seen that the ability of the international community to enforce rights is weak in comparison to most domestic systems of legal enforcement, the influence that the concept of human rights has already had on societal development should not be under-estimated. Change that impacts on state sovereignty is endemically slow because of an obvious reluctance to limit its own power. Still it has occurred. Concepts are gradually expanding to consider the effect of important non-state actors on rights and to break down the artificial distinction between public and private spheres of state responsibility.[36] However, one can only

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[35] As will be discussed in more detail in chapters 5 and 8, the information gathered from states to ensure compliance with the Health-for-All initiative provide vital information which could be used to monitor and assess protection of the right to health but some further accommodations would also be necessary.

[36] This artificial differentiation has been vilified by many feminist commentators For examples see:
Charlesworth, H. (1993): 'Alienating Oscar? Feminist analysis of international law' in Dallmeyer, D. (ed.) Reconceiving reality: women and international law.
Cook, R. (1994): 'Women's international human rights law: The way forward' in Human rights of women, pp.3-36.
Sullivan, D. (1995): 'The public/private distinction in international human rights law' in Peters, J. and Wolper, A. (eds.), Women's rights, human rights, pp.126-134.

agree with Mann that when faced with the recent challenge of genocide prevention,[37] rights violations by non-state actors or in places without a viable state structure, current mechanisms have been found to be wholly inadequate. So that "[w]hile traditional modes of work are still extremely useful – as is also the case in public health – new forms of action to promote and protect human rights are clearly needed".[38] In order to overcome this problem, the concept of rights have to move away from focusing solely on the obligations and duties of states and focus more on facilitating human flourishing. In order to do this consideration needs to be addressed to all actors who impact on the individual and more attention needs to be directed towards giving a voice to individuals and local communities.

**D. Conclusion**

Fundamental human rights are inalienable and are entitlements due to the individual by virtue of being human. They are the minimum rights necessary for a life of dignity. Human rights are not just legal concepts but also have political, moral and economic components. However, the rooting of human rights in the rule of law has been extremely important for defining the rights and obligations to be protected as well as providing an avenue for redress of violations. It has also facilitated the social internalisation of rights. Similarly, health or ill health is part of this same dialectic process. Society's concept of health or human flourishing is grounded in the collective perpetual creation of an individuals' self, their world and the power relations that impact on them. Therefore, it is important that human rights are not unduly restricted to obligations and duties on states but are allowed to develop to promote and protect the essential dignity of the individual in the manner most appropriate for the current societal environment. To date, the principle focus of attention for international law has been to limit the power of states by determining their obligations and duties in respect of human rights. Most importantly this has led to the drafting of international human rights treaties and the establishing of treaty bodies to protect fundamental rights.

[37] Because genocide is uncontrovertibly internationally recognised as an illegal and immoral act it is used here as an extreme example of the weakness of the international system which could not prevent millions being massacred in Rwanda and the former Yugoslavia.
[38] Mann (1997), p.115.

## 2.
## Evolution of the right to health

The right to health has been dismissed as a concept too vague to have practical utility. This perception has been re-enforced by the problems that have arisen in the attempt to define the notion of health itself. These difficulties are analysed in the first part of this chapter.

In spite of these difficulties, the right to health has, to some extent, been codified in numerous human rights treaties and human rights treaty bodies have been established to promote and protect the obligations so enshrined. In this way, a legal framework is established in relation to the right to health and legal obligations arise as a result. These treaty provisions are extremely important, as without them it would be difficult to argue that the right to health has legal effect. Consequently, in the second part of this chapter, the relevant treaty provisions will be examined in detail.

Despite this codification of the right to health and the jurisprudence of the treaty bodies serving to enact the right, the concept of the right to health has remained controversial. A number of UN conferences have expounded aspects of the right, while various publicists have sought to develop a better understanding of the right to health. Their work will be examined in the final section of the chapter. The aim of this chapter is to examine how the concept of the right to health has evolved so as to place the current status of the right to health in context.

### A. Debating the meaning of the term 'health'

Despite the fact that the word 'health' is in constant common usage, its actual meaning is difficult to determine because health is a subjective concept. Not only is it historically contingent but the concept of health also has strong cultural and geographical elements. The western concept of health based on medical intervention is a 19th century development with its origins in Europe's public health movement.[1] For other cultures, the western concept neglects the spiritual element of health such as the Hindu interpretation of health as being spiritual freedom or enlightenment.[2] Butcher, on the other hand, would rather define human

[1] Fluss, S. (1995): 'The development of national health legislation in Europe: the contribution of international organizations'. Vol.2 European journal of health law, pp. 193-237, p.203. See pp.203-205 for a brief history of health in Europe.
[2] In Jamar, S. (1994): 'The international human right to health'. Vol.22 (1) Southern University law review, pp.1-68, p.11 fn. 20.

health in legal terms as "a claim, interest, need or demand which is cognizable under law and which proceeds from moral precepts necessary for respect for human dignity".[3]

There is no agreement as to a legal definition of health and there is often disagreement between the medical and legal professions in this regard as each seeks to emphasise aspects particularly pertinent to their needs. When the international community considers the notion of health it is normally with reference to the definition found in the Constitution of the WHO: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'[4]

This definition is then invariably dismissed as all encompassing and as such too broad to be useful.[5] While it is all encompassing, the value of this definition lies, perhaps, in the recognition that health is not only a physical, but also a mental and social concept. The Secretariat of the WHO has proposed amendment to this definition so that it would read as:

> Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity.[6]

Recognition of the fluid nature of health, found in the words 'dynamic state,' could be particularly useful when coupled with the notion of the right to health. Certainly, it better reflects the pluralistic and competing value-systems that exist in today's society, which is essential if health is going to be addressed at the international level. However, it also successfully encapsulates the historically contingent element of health. It remains to be seen whether this amended definition is taken up by the international community.

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[3] Ibid., p.15.
[4] Found in the Preamble to the WHO's Constitution. See Annex 1 for full text.
[5] Within the confines of this paper it is not possible to discuss at length the various theories and definitions on health. See:
Sigerist, H. (1941): Medicine and human welfare;
Tempkin, O. & Tempkin, C. (eds.)(1967): Ancient Medicine;
Fluss, S. (1997): 'International public health law: an overview' in Detels, R., Holland, W., McEwen, J. & Omenn G. (eds.), 3rd ed., Vol.1, Oxford textbook of public health, pp.371-390;
Campbell, A. (1995): 'Defining core health services: The New Zealand experience.' Vol. 9, No.3/4 Bioethics, pp. 252-258;
Daniels, N. (1983); 'Health care needs and distributive justice' in Bayer, R., Caplan, A. & Daniels, N. (eds.), In search of equity, health needs and the health care system, pp.1-43.
[6] 52nd World Health Assembly, April 1999, Official Records A52/24, 'Amendments to the Constitution: Report by the Secretariat,' p.4.

The definition of health was broadened even further at the Women's Conference in Beijing, 1995, where it was affirmed in Article 91 that:

> Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well being and their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being, and is determined by the social, political and economic context of their lives, as well as by biology.

Not only does this definition assert that 'social well-being' can have a significant impact on an individual's health, but it also clearly considers empowerment an important factor. In relation to reproductive health, the notion of 'complete physical, mental and social well-being' was further elaborated on to provide practical direction for concerned parties. This is set out in Article 96:

> Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.[7] Reproductive rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.[8]

While both these definitions build on the WHO's definition of health, the latter example highlights the importance of empowering the individual to protect her/his health through knowledge. Expansion of the original definition in this way reiterates that the original definition provides a useful starting block from which to begin considering the expansive elements of health.

It is clear, however, that to the extent any definition of health reflects a particular philosophical position and/or is rooted in a sociological process, it must necessarily impact on the notions embodied in the right

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[7] Article 7.2 of the text affirmed at the Cairo Conference continued with:

> "Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive heath, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."

[Using text available at http://www.iisd.ca/linkages/Cairo/program/p04001.html - 1/19/99.]

[8] Article 96 of the document from the United Nations Conference on Women, Beijing, 1995. Using text found at http: /www.iisd.ca/linkages 4wcw dpa-028.html - 1/21/99.

to health and effect its development. This adds to the difficulty in providing a succinct final definition of the right to health. One of the challenges for the future of the right to health lies in reconciling different value systems and interests that encompass global health.

Nevertheless the fact remains that health is an everyday concept that is utilised and developed within the local, national and international community. It must, therefore, be possible to establish the practical elements of the right to health even if an esoteric definition remains elusive. The WHO has functioned with measured success, for the past 50 years on the basis of its current definition of health but has done so using a biomedical model of health and illness.[9] By so doing, it has failed to acknowledge the value-laden judgements that it is making,[10] concerned that to acknowledge value judgements have a role in defining the right to health would be to undermine the objective and universal foundation of health care and medical science.[11]

Toebes argues that the right to life and the right to privacy also proclaim subjective values, making an abstract definition equally difficult to determine, but this has not prevented these rights being considered justiciable.[12] Indeed, international and national jurisprudence has helped shape the specific meaning and significance of these rights. Therefore, she argues, frequent application of the right to health before international and national (quasi-) judicial instances may do the same for the right to health. To date, as her research shows, there has been little development in this regard and there is no reason to suspect that the

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[9] One such view suggests that because all organisms are the product of a long course of biological evolution, health is the functioning of any organism in conformity with its natural design.[Caplan, A. (1981) The concepts of health, illness, and disease in Caplan, A., Engelhardt, H., & McCartney, J. (eds.) Concepts of health and disease: interdisciplinary perspectives, p.66-67.]
Another view considers disease to be anything that is statistically abnormal and therefore health is what has been most commonly detected by statistical measurement as normal. [Caplan (1981), p.67-68.]
The result in both cases is to establish health as scientific and objective.

[10] Normativists would argue that:

> "health, illness and disease are inherently value-laden, and to fully understand these concepts, one must realize that decisions about states of mind or body involve considerations of what is good, bad, desirable, or undesirable." [Caplan (1981), pp.57-58.]

[11] Such conclusions are dependent on one's notion of values and whether judgments of value can be amenable to objective reasoned argument or not.
Caplan agues that:

> '[i]f it is possible to obtain agreement among rational human beings that some states of body or mind are valuable and desirable, but others are not, it ought to be possible to accord an explicit role to values in the definition of disease and health without sacrificing objectivity, precision, or universality.' [Caplan (1981), p.71.]

[12] Toebes, B. (1999): The right to health as a human right in international law, p.24.

level of case law is likely to change in the near future. I would argue that until there is a greater international consensus as to the legal meaning of the right to health that position is unlikely to change.

Yet, it may be more appropriate to determine a practical and effective process in which the right to health can function and evolve rather than to seek an elusive, timeless definition. Various attempts to outline the right to health have been made at the international level in the form of treaties and the interpretative work of the respective human rights treaty bodies. Analysis of these approaches is important to determine whether the right to health is to have practical utility.

**B. Establishing a legal framework for the right to health**

Following World War II and in an effort to prevent similar atrocities from occurring again, the UN system was established. Protection and promotion of human rights were considered to be an important part of its mandate as was the promotion of health. Article 55 of the UN Charter[13] directed the United Nations to promote "solutions of international economic, social, health, and related problems..."[14] Co-operation on health issues was deemed necessary to create "conditions of stability and well-being which are necessary for peaceful and friendly relations among nations...".[15]

The Universal Declaration on Human Rights was the first codification of human rights and was endorsed by a resolution of the UN General Assembly. Although not binding in terms of international treaty law, it was extremely influential. In fact, many articles of the Declaration are now considered to be binding under customary international law and the two principle human rights treaties were derived from this initial Declaration.[16] There is now an international human rights treaty system establishing a legal framework for the protection of human rights. Pivotal within this system is the human rights treaty bodies that have the legitimate authority to interpret provisions of individual human rights treaties. In addition, these bodies

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[13] UN Charter, adopted 26 June 1945, entered into force 24 Oct. 1945.

[14] Ibid., Article 55b.
While the article was merely a commitment to promote solutions to health problems, it provided an indication of the level of priority considered appropriate to health issues at the time.

[15] Ibid., Article 55.

[16] Academics have argued that much of the Universal Declaration on Human Rights, 1948, has become customary international law due to overwhelming state practice but whether the same is true of the ICCPR or ICESCR is more debatable.
See: Schacter, O. (1991): International law in theory and practice, at pp.335,336 and 342 and McDougal, M., Lasswell, H. & Chen, L. (1980): Human rights and world public order, at pp.274,325 and 338.

have the power to request and critique state reports, influence formulation of policy through diplomacy and direct the action of states as well as utilising specific mechanisms designed to enforce legal obligations derived from the particular treaty.

## 1. International human rights treaties and treaty bodies

The Universal Declaration of Human Rights[17]

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

It is unfortunate that the issue of human health was combined with other social and economic issues into a single article and that there is no clear acknowledgement of a right to health. Buergenthal, however, suggests that the right to health is 'expressly recognized'[18] and is supported in this approach by Judge Weeramantry who states that "Article 25(1) of the Universal Declaration recognises the right of everyone to health and well being, though its stress is on the right to a standard of living adequate for health and well being".[19] I would argue that the result is a confusingly broad attempt to determine a right centred on the vague phrase 'standard of living' that adds little to a determination of the right to health. This utilisation of 'western' or 'developed' country terminology and the association of fundamental human needs with social security issues regrettably emphasises that, for many people, health is an unobtainable luxury of industrialisation thereby negating the potential impact that a right to health can have an effect even in poor communities.[20] The measure of the right protected in Article 25 could be very low, as it is dependent on an interpretation of 'adequate'. For example, if an ungenerous interpretation were to be placed on the standard established, the meaning could merely be enough for life to be sustained.[21]

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[17] Adopted Dec. 10, 1948, G.A. Res. 217A (III), UN Doc. A/810, at p.71.

[18] Buergenthal, T. (1989): 'International human rights law and institutions' in Fuenzalida-Puelma, L. and Connor, S. (eds.): Right to health in the Americas : a comparative constitutional study, at p.6.

[19] In his dissenting opinion in the *Legality of the Use by a State of Nuclear Weapons in Armed Conflict* case [advisory opinion, ICJ reports, 1996] at p. 31.

[20] While the right to a safety net of social services does little to inform our understanding of a right to health it can act as an indicator as to the consequences of a lack of health. "If one does not have health and does not have the ability to purchase medical services and other conditions conducive to health, then a claim for those services exists." [Jamar (1994), pp.21-22.]

[21] Food, warmth, shelter, physical health and minimal financial support are merely the essentials to sustain life in modern society.

Because the list of socio-economic needs in Article 25 is open-ended, it is difficult to establish any clear understanding of a person's health entitlement. A person's 'health' and 'well-being' are considered separately suggesting that the notion of health does not necessarily encompass personal well being. Combined with the fact that only 'medical care' is specifically listed as necessary for an adequate standard of living leads one to conclude that the drafters of the Declaration were concerned with a narrower definition of health but, nevertheless, one with a social component. Separating out mothers and children for particular attention, entitling them to 'special care and assistance' in paragraph 2 of Article 25, highlights the concern to ensure that the health needs of this vulnerable group receive particular attention and protection. While Article 25 acknowledges the connection and impact of one's physical environment to health in the context of housing, food and social services, the focus is only on an individual's microenvironment and leaves no protection from the equally influential macro-environment.

While Article 25, itself, provides limited material to determine the right to health, there is much to be gleaned from the broader text of the Universal Declaration of Human Rights that is helpful in the development of the right to health. It was the first comprehensive proclamation of the rights of the individual and has subsequently attained a unique legal status within the international arena.[22] Because it calls for the recognition of civil and political rights along side economic, social and cultural rights it established the conceptual interrelationship and interdependence of these rights. Of equal importance were the fundamental human rights principles that were enshrined within it: e.g. the Preamble emphasised the 'inherent dignity' and 'equal rights' of men and women and this was reiterated in Article 1: "[a]ll human beings are born free and equal in dignity and rights". Article 2 established the principle of non-discrimination.[23] Because the obligations of equality and non-discrimination were linked to all the rights established under the Universal Declaration, they have become established as principles that underpin the

[22] Because the Universal Declaration was not a treaty it did not create legally binding obligations but it has since evolved into an extremely important normative instrument which creates legal obligations. It remains unclear, however, whether all the rights proclaimed are binding and how this has been achieved. (It is possible to argue that the Declaration was merely an authoritative interpretation of the human rights obligations of the UN Charter while others suggest it has attained this position through assimilation into customary international law.)
Buergenthal (1989), p.6.

[23] Article 2: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

human rights system and as such their essence must impact on any interpretation of a human right including the right to health.[24]

Article 25 is not the only article concerned with issues of health. There are some rights, which if violated, would obviously impact on the health of the individual whereas there are other articulated rights that have a more indirect impact on a person's health. [25] This latter list becomes difficult to define due to the interconnectedness of rights and can only be established by describing the degree of impact.[26] If a right is to have a separate identity, there must be a distinction between the fundamental nature of a right and its influence and relationship to other rights. The concept of layers of rights within a right is important to any attempt to define a right. Encapsulated within any such right is an element that is fundamental whereas there may also be other elements that reflect broader moral, legal or social issues, singularly or in combination.

The International Covenant on Economic, Social and Cultural Rights[27]

The ICESCR along with the ICCPR were designed to transform the principles identified in the Universal Declaration into binding treaty obligations under international law. It is in the ICESCR that the 'right to health' is first identified as a legally binding right.[28]

Article 12 of the ICESCR states:

1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2) The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
a) the provision for the reduction of the still birth-rate and of infant mortality and for the healthy development of the child;
b) the improvement of all aspects of environmental and industrial hygiene;
c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;

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[24] Particularly, as these principles are reiterated so forcefully in the ICCPR (Articles 2.1 and 3) and ICESCR (Articles 2.2 and 3).
[25] Article 3, 'Everyone has the right to life...', Article 4, 'No one should be held in slavery...' , Article 5, 'No one shall be subjected to torture...' would obviously come in this category.
[26] Any violation of Article 23, 'Everyone has the right to work...' Article 24, 'Everyone has the right to rest and leisure...' and Article 26, 'Everyone has the right to education...' could clearly have an impact on an individual's health but so could Article 6, 'no one shall be subjected to arbitrary arrest...' and Article 20, Everyone has the right to freedom of peaceful assembly...' in certain circumstances.
[27] Adopted Dec. 16, 1966, entered into force 3 Jan. 1976, G.A. Res. 2200A (XXI), UN Doc. A/6316 (1966), 993 UNTS 3.
[28] Indeed, the ICESCR arguably provides "the fullest and most definitive conception of the right to health." Chapman, A. (1998): 'Conceptualizing the right to health: a violations approach.' Vol. 65 Tennessee law review, pp. 389-418, at p.397.

d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

In this provision, health is simply separated into the components 'physical and mental health'. This definition follows the definition of health in the Constitution of the WHO except that the final draft of the ICESCR failed to include the 'social well-being' component advocated by the WHO. The presumption being that under the ICESCR the right to health is to be more narrowly defined.[29] It has been argued that the use of the word 'recognize,' allows the state a broader discretion in interpreting the right being considered.[30] I would, however, suggest that use of the word recognise acknowledges the fundamental nature of health to the individual and her/his social existence, regardless of the state's standpoint, by invoking the notion of natural rather than positive law. Adopting a more realistic standard for the right to health, namely '[t]he highest attainable standard...', may have been an attempt to circumvent the potential difficulty arising from the wide comparative variation in existing health standards of states but in so doing has made a precise definition of the 'right to health' more difficult.

There is academic controversy as to the nature and effect of Article 12.2. Its inclusion can be seen as an attempt to clarify the content of the right to health by providing examples of areas to be considered by a state in order to fulfil its obligation. This list is not inclusive and would be detrimental to the attainment of Article 12.1 for it to be so. For Taylor, goals rather than actions are prescribed in Article 12.2 and these simply identify areas of priority to be addressed.[31] If these 'goals' were considered to be substantive indicators,[32] their role and function become more important because each Member State would be under a legal obligation to realise these provisions.[33] The list provided does present a broader picture of a state's obligation to the right to health. A priority risk group is defined (12.2.a), traditional public health concepts

[29] The ICESCR seems to have adopted the medical model of health rather than the holistic model found in the Constitution of the WHO. See chapter 4 for further details.
[30] Jamar (1994), p.23.
[31] Taylor, A. (1992): 'Making the World Health Organisation work : a legal framework for universal access to the conditions of health'. Vol.XVIII No.4 American journal of law and medicine, pp.301-346 at p.326-7.
[32] This is the view taken by Fuenzalida-Puelma, L. and Connor, S. (eds.) (1989): Right to health in the Americas: a comparative constitutional study, at p.600
[33] Currently, states are requested to submit an initial report and then to submit further reports every five years dealing with the entire ICESCR.

are utilised (12.2.b&c) and medical services are singled out for consideration (12.2.d), but no specific obligations are ascertainable.[34]

A more accurate description of Article 12.2 would be as a listing of "...some of the fields in which efforts are to be made to ensure enjoyment of the right".[35] This description does not prevent the list from aiding the identification of obligations placed on the duty-holder.[36] If one accepts that Article 12.2 simply provides a list of areas for consideration by any state trying to attain the highest attainable standard of physical and mental health then its impact on a definition of a right to health is more limited. Access to some form of medical services would seem to be a central feature and would support the chosen medical model definition of health, but improvement in the field of environmental and industrial hygiene would equally suggest a broader dimension to the right. Certainly, the weight of Article 12 lends support to the notion that guaranteed access to health care is central to a definition of the right to health.[37] Unfortunately, as Chapman points out, the article fails to include major components of women and children's health needs, therefore reflecting a male-oriented concept of health. If not rectified this failing could seriously limit and debase the content of the right to health.

The Committee on Economic, Social and Cultural Rights

The Committee on Economic, Social and Cultural Rights supervises the implementation of the ICESCR and therefore applies and interprets it as needed. The Committee has utilised the procedure of adopting

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[34] The specifics given in Article 12.2 remain too general and broad to be classified as indicators. True indicators require specific limits and/or ranges by which comparison of data is to be made and this can only be monitored by the attainment of consistent data. See chapter 8.

[35] Jamar (1994), p.26.
He goes on, at p. 27, to distinguish between the right and the steps necessary to be taken in order to achieve this right: "[t]he distinction is one between a status (healthy) and a process (steps to enhance ability to achieve the desired status)."

[36] Ibid., p.27.
> "Viewed from the obligation perspective, the idea is that a state cannot guarantee or provide health directly; it can only provide conditions conducive to the attainment of health. This characteristic distinguishes health from virtually every other human right, even the other social and economic rights."

It is important to note that Jamar views the duty-holder as the state alone and the right holder as the individual alone.

[37] Cook, R. (1986): 'Human rights and infant survival: a case of priorities.' Vol.18 Columbia human rights law review, pp. 1-41, at p.14 and
Tomasevski, K. (1995a): 'Health rights' in Eide, A., Krause, C. & Rosas, A. (eds.), Economic, Social and Cultural Rights: a textbook, pp. 125-142, at p.129.

general comments to assist the state parties to meet their reporting obligations, to stimulate activity in a particular area and to improve reporting procedures.[38] "Although the Committee's interpretations of the Covenant are not binding *per se*, it is undoubtedly true that they have considerable legal weight."[39] The relevant interpretations are discussed below.

i) *'The nature of states parties obligations,' General Comment No.3*[40]

Here the Committee addresses the nature of States parties obligations, in general. Important distinctions are made to categorise and distinguish these obligations. Firstly, the Committee endorsed the work of the International Law Commission by accepting the differentiation made between 'obligations of *conduct* and obligations of *result'*.[41] Such distinction becomes pertinent to the development of indicators to monitor the right to health.[42] Secondly, despite the provision within the Covenant for progressive realisation, the Committee holds that certain obligations are imposed that should have *'immediate effect.'* Emphasis is placed on the 'undertaking to guarantee' that relevant rights 'will be exercised without discrimination' and the undertaking to *'take steps'*. "Such steps should be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant."[43] Even when considering the 'progressive realization' of obligations, there remains "an obligation to move as expeditiously and effectively as possible towards that goal". These distinctions provide the Covenant with meaningful practical content and disaggregate the obligations in a useful manner. Furthermore, State parties are encouraged to consider not only the administrative, financial, educational and social measures to give effect to the Covenant but also that they should use 'legislative measures'. Indeed, the comment specifically highlights the field of health, the protection of children and mothers, and education as areas where legislation would be an 'indispensable element' to be addressed.[44]

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A. Chapman identified a number of specific government obligations as well as a series of criteria that formed the core content of the right to health in Chapman, A. (ed.) (1994): 'A human rights approach to health care reform' in Health care reform: a human rights approach, pp.149-163.

[38] The Committee on the Economic, Social and Cultural Rights' authority to prepare general comments on the various articles and provisions of the Covenant is derived from an invitation by ECOSOC to do so. ECOSOC Resolution 1987/5 (26 May 1987), in UN Doc. E/C.12/1989/4, (1988).

[39] Craven, M. (1998): The International Covenant on Economic, Social and Cultural Rights: A perspective on its development, p.91.

[40] UN Committee on Economic, Social and Cultural Rights: The nature of states parties obligations (Art.2, par.1), General Comment 3. UN Doc. E/1991/23.

[41] Ibid., para. 1.

[42] See Chapter 8.

[43] Para. 2 of General Comment No.3.

[44] Ibid., para. 3.

> "...[T]he Committee is [also] of the view that a *minimum core obligation* to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party."[45]

The list of examples then provided that significant deprivation of "...essential foodstuffs, of **essential primary health care**, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant".[46] Therefore the Committee, at least in general terms, considers there is a minimum core obligation in the right to health and presumably is using the notion of primary health care as advocated by the WHO in its Health-for-All initiative.[47] Interestingly, all the specified minimal obligations highlighted above could be incorporated in a broad definition of the term right to health. While these comments are of a general nature, they provide a useful means of dissecting the issues likely to be of concern to the Committee in relation to the right to health.

ii) *Day of general discussion on the right to health at its ninth session*[48]

In December 1993, the Committee on Economic, Social and Cultural Rights organised a day of general discussion on the right to health at which the Vice-Chairperson, Mr. J. Alvarez Vita offered a series of conclusions concerning the right to health. Such comments expand on the generality to provide useful insight as to the Committee's perspective on Article 12 at that time.

Mr. Alvarez Vita made it clear that the right to health was applicable in two spheres, namely within states and at an international level, with the beneficiaries being not only the human person but also human communities. Highlighted was the 'indivisibility, interdependence and interrelationship' of the right to health with other human rights that led to the incorporation of equality in dignity, participation, entitlement and non-discrimination being characteristics of the right to health. For example, strong efforts should be made to eliminate discrimination against women, children, victims of AIDS, and ageism. Mr. Alvarez Vita also stated that there is a need to recognise the impact that economic discrimination has on an individual's health, especially by limiting one's access to health care.

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[45] Ibid., para. 10.
[46] Ibid., bolding added.
[47] To be discussed in chapter 4.
[48] See generally Report on the Eighth and Ninth Sessions, UN ESCOR, Supp. 3, UN Doc. E/1994 23, E/C.12/1993/19.

Of particular interest was the emphasis placed on states' responsibilities to act collectively. The recommendation was made that a detailed report on this issue should be part of the developing countries submission to the Committee on Economic, Social and Cultural Rights. Such a report would state the support received and the outcome it generated. Mr. Alvarez Vita considered it feasible and necessary to set a minimum level of co-operation below which a co-operating state would be considered to have failed to comply with international obligations. This put the onus on developing states to seek aid from other states and utilise it effectively under the 'principle of solidarity'.[49]

This principle of solidarity implicitly requires a change in attitude towards international relations and has the potential to open up an important new role for the WHO. If the right to health is to be the responsibility not only of states individually but also collectively as well as non-state entities and the human person, there would need to be a more accessible channel of communication with a facilitator to co-ordinate, monitor and assess activities undertaken.[50]

Mr. Alvarez Vita's asserted that it was not possible to set a minimum standard for the right to health because the standard established is that of "the highest possible level of health" and it would be equally unfair to allow states to set varying limits related to their level of development.[51] However, he argued that it is still feasible to monitor compliance with the right to health by use of comparative study to ascertain whether there has been relative "progress, regression or stagnation in the enjoyment of the right to health".[52] This would require regular and consistent data collection and assessment preferably utilising an internationally compatible system and would require technical skills that are well established in the WHO. What criteria are considered pre-eminent to assess and ensure the highest possible level of health? Is the notion of a minimum core obligation within the right to health compatible with this approach? Recurrent throughout was the assertion that the main obligation in health matters was the need to maintain human

[49] Ninth session, para. 292.7.
[50] Ibid., para. 292.10.
[51] Ibid., para. 292.9.
In so doing the right to health is being distinguished from the generality of rights under the ICESCR which are considered to give rise to a 'minimum core obligation'. This reflects a potential limitation for the subsequent development of a definition of the 'right to health'. However, attainment of the "highest possible level of health" does not negate the assertion that there is a fundamental core right that is elemental.
[52] Ninth session, para. 292.5.

dignity, but Mr. Alvarez Vita did not provide practical details in terms of standards and indicators that the Committee on Social, Economic and Cultural Rights would require.[53]

iii) *Reporting guidelines of the Committee*

The present reporting guidelines of the Committee concerning Article 12, request that States parties provide background information on: "the physical and mental health of the population, both in the aggregate and with respect to different groups within [the] society"; the existence of a national health policy; and the percentages of the GNP as well as national and regional budgets that are spent on health care.[54] *Where available,*[55] States parties are also asked to provide indicators in relation to the following issues: [56]

a) Infant mortality (... by sex, urban/rural division, and ... if possible, by socio-economic or ethnic group);
b) Population access to safe water ( ...disaggregate[d by] urban/rural);
c) Population access to adequate excrete disposal facilities (...disaggregate[d by] urban/rural);
d) Infants immunized against [major diseases] (disaggregated by sex and urban/rural);
e) Life expectancy (...disaggregate[d by] urban/rural, by socio-economic group and by sex);
f) Proportion of the population having access to trained personnel for the treatment of common diseases and injuries, with regular supply of 20 essential drugs, within one hour's walk or travel;
g) Proportion of pregnant women having access to trained personnel during pregnancy and proportion attended by such personnel for delivery,... including maternity mortality rate, both before and after childbirth;
h) Proportion of infants having access to trained personnel for care.'[57]

While no minimum standards are advocated, these indicators illustrate the manner in which the Committee considers Article 12.2 should be implemented. However, the fact that these indicators correspond closely to the indicators used by the WHO to monitor and assess the effect of its Health-for-All policy suggests that the Committee believe, in terms of implementation, that there is a strong correlation between the two concepts. As a result, these indicators could provide the basis of a core minimum obligation on State parties.[58]

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[53] Except to mark out coercive birth control practices for special attention.
[54] Alston, P. (1991): 'The International Covenant on Economic, Social and Cultural Rights' in United Nations Centre for Human Rights, Manual on human rights reporting. Reproduced in Chapman, A. (1995): 'Monitoring women's right to health under the International Covenant on Economic, Social and Cultural Rights'. Vol.44 The American University law review, pp.1157-1175 at p.1167.
[55] Emphasis added.
[56] These indicators were originally defined by the WHO.
[57] Alston (1991), pp.1167-1168.
[58] See chapter 5 for detailed discussion of these points.

The reporting guidelines also seek to elicit information within the country on groups whose health situations are "significantly worse than that of the majority of the population" and an indication of the measures the government has taken to improve their health. In addition, the guidelines ask about measures "to maximize community participation in the planning, organization, operation, and control of health care [and] ...to provide education concerning prevailing health problems" with regard to prevention and control.[59] It is unfortunate that submission of this data is not mandatory. As a result, few states provide data on a disaggregated basis, and the Committee rarely criticises states for failing to do so.[60] So far, the Committee has not attempted to analyse independent health data available within the UN system. This is partly because the Committee lacks the necessary staff to collect and assess such data but also because the Centre for Human Rights does not have access to statistical databases held by the United Nations and its specialised agencies, including the WHO.[61] It would seem an unnecessary duplication for the Committee to collect and process this information when a competent and affiliated body already has access, or potential access, and the expertise to process the data. Currently, however, the WHO neither provides assistance to the Committee nor does it seek to collect or evaluate health data on a human rights basis. Its sole contribution is, on occasion, to send a staff member to attend some of the Committee's sessions.[62]

The International Covenant on Civil and Political Rights[63]

The ICCPR has no express provision concerning the right to health, but it does contain provisions that can be considered to impact on such a right e.g. the right to life (Article 6), to freedom from torture (Article 7), to liberty and the security of the person (Article 9), to humane treatment of prisoners (Article10), to freedom of thought, conscience and religion (Article 18), and to freedom to seek, receive and impart information (Article19). Violation of any of these rights would affect an individual's health or enjoyment of the right to health, but this does not mean that the right to health has to be contained within or bound by these rights. Indeed, this illustrates the overlap and interconnection of rights and the problem of trying to

[59] Chapman, A. (1995): 'Monitoring women's right to health under the International Covenant on Economic, Social and Cultural Rights'. Vol.44 American University law review, pp.1157-1175 at p.1168.
[60] Ibid.
[61] Ibid., p.1167.
[62] The WHO did submit a brief report in 1980 on the implementation of the Covenant – UN Doc.E/1980 24; and a report was also submitted by the Global programme on AIDS – UN Doc.E/C.12/1995/WP.1.
[63] International Covenant on Civil and Political Rights, adopted Dec. 16, 1966, entered into force 23 March 1976, G.A. Res. 2200A (XXI), UN Doc. A/6316 (1966), 999 UNTS 171.

define one right in relation to others.[64] "The right to health, if it is to have meaning apart from these rights and other social and economic rights, must have some discrete domain."[65] However, this is not to deny that an issue may be considered a right under the right to health as well as under the ICCPR. Indeed, as Steiner and Alston noted in relation to a case study on female circumcision, the level of response can vary depending on the terminology used, to the extent that there may even be a grassroots advantage to an issue being considered under the auspices of the right to health. [66]

The ICCPR and consequently the Human Rights Committee, as its monitoring treaty body, has to deal with several health-related issues stemming from the right to life, freedom from torture, etc. But, because these subjects are only occasionally of direct concern to the Committee and are handled in a manner consistent with the Committee on Economic, Social and Cultural Rights, there is little to be gleaned in relation to the right to health.[67]

International Convention for the Elimination of All Forms of Racial Discrimination[68]

CERD is a specialist treaty so it is not surprising that the emphasis throughout is on racial equality and non-discrimination. The narrow focus of this treaty does, however, make difficult any attempt to use the treaty to aid in the broader definition of the right to health. The right to health *per se* is not listed among the rights to be enjoyed. Instead, the consideration of health is divided into the right to public health and the right to medical care. Because the list provided for in Article 5 is not exclusive, the inference cannot be that these two rights combine to establish the right to health. All that can be said is that prevention of disease and access to medical services are areas where there is a higher potential risk of discrimination. It

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[64] It is perhaps unfortunate that the ICCPR and ICESCR had, for political reasons, to be developed as two separate treaties with independent monitoring systems.

[65] Jamar (1994), p.28.

[66] In the book by Steiner and Alston, the issue of the right of the child not to be circumcised was considered as an issue concerning the right to health but also in terms of a political right. The African women interviewed felt that when seen as a political right a judgement was being made. This discomfort was not present when discussing the issue in terms of a right to health.
[Steiner & Alston (1998): Human rights in context, p.247]

[67] See Toebes (1999), pp.159-166, for a more detailed analysis of the work of the Human Rights Committee in this field.

[68] Adopted Dec. 21, 1965, entered into force Jan. 4, 1969, 660 UNTS 195, reprinted in 5 ILM 352 (1966).
Article 5
In compliance with the fundamental obligations laid down in Article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms an to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:
...(e)(iv) the right to public health, medical care, social security and social services;

would seem reasonable to suggest that these two elements must necessarily be components of the right to health. But does this then mean that the right to social security and the right to social services, also mentioned in Article 5 of CERD, are therefore encapsulated within the right to health? While an individual requires some means of obtaining food, clothing and shelter in order to maintain a reasonable level of health, it would be a very broad definition that incorporated these automatically within the definition. Similarly, it cannot be denied that many people with poor health require the support of social services, particularly in the Western world where social services work closely with health professionals to provide ancillary health services. It is, perhaps, feasible to suggest that this combination of rights, as expressed in Article 5(e)(iv), was influenced by the wording of Article 25.1 of the Universal Declaration on Human Rights and simply reflects the social approach to health of these rights.[69]

The Declaration on Social Progress and Development (1969)[70]

While the content of the Declaration on Social Progress and Development is not legally binding, it is of particular interest to the right to health. Article 10 establishes some new goals for health and may indicate a shift in societal attitude towards the right to health as it establishes a maximum standard of health.[71] This may either reflect a more optimistic attitude towards societal health or it may simply be a reversion to the standard language of human right texts.[72] However, there is a separation of the health of the individual from the health of the broader community, which is an interesting development. The right to health is considered to incorporate both elements, if this goal is to be achieved. But because the higher standard is used to define the health of the individual alone, does this imply that the health of the community cannot be protected to the detriment of individual health? Unfortunately, no further clarification is provided to aid in distinguishing between 'health' and 'health protection'.

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[69] It is important to consider whether simply because an action or inaction may be detrimental to an individual's health is sufficient reason for it to be considered an element of that individual's 'right to health'.

[70] Proclaimed by General Assembly Resolution 2542 (XXIV) of 11 December 1969.
Article 10
Sets the goal of "the achievement of the highest standards of health and the provision of health protection for the entire population, if possible free of charge."

[71] This is certainly higher than "the highest attainable level of health" in Article 25 of the ICESCR.

[72] The texts of all human rights treaties use idealistic language. This has been the subject of academic debate but generally this idealism is seen to be inspirational and important to ensure that these texts do not become outdated by future technological events. The language used when considering the individual's health, however, has been conspicuously more narrowly and cautiously defined.

The approach in the Declaration on Social Progress and Development recognises that global health has become an essential element of health. States no longer have a duty or obligation solely to their own citizens but to the international community as well. In modern society, if one is to expand the context of the right to cover international health, then financial matters become even more crucial. Here, the goal is established that health of the individual and the international community be attained 'free of charge'. Unless the entrenched capitalist system is replaced, it is difficult to envisage how such a goal is to be achieved. Cost and payment are integral dilemmas to be addressed in the provision of all rights, especially in relation to social and economic rights. The question is rather on whom the burden of payment should rest? The Committee on Economic, Social and Cultural Rights requires that states with insufficient economic resources seek international assistance and there is a reciprocal obligation on more affluent states to render assistance.[73]

Convention on the Elimination of All Forms of Discrimination Against Women[74]

CEDAW is another specialised treaty that specifically seeks to reinforce the human rights principles of non-discrimination and equality, so analysis of it in the context of the right to health has to be tempered. Jamar considers that the use of 'protection' in Article11.1 (f) "...implies the taking of steps to create the conditions conducive to good health, or at least to avoid conditions antithetical to health."[75] It is used in

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[73] General Comment No. 3, paras. 13 and 14.

[74] Adopted Dec. 18, 1979, entered into force 3 Sept. 1981, G.A. Res. 34/180, 34 UN GOAR, Supp. (No. 46), UN Doc. A/34/46, at 193 (1979), reprinted in 19 ILM 33 (1980).

Article 11

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(f) The right to protection of health and to safety in working conditions including the safeguarding of the function of reproduction.

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 14

3. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on the basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

b) To have access to adequate health care facilities, including information, counselling and services in family planning;

[75] Jamar (1994), p.29.

Jamar also argues that it is the first use of this phrase but as has already been shown a similar phrase was used in the Declaration on Social Progress and Development where its use was much less ambiguous.

relation to occupational health issues only and so I would argue that it is merely context specific. It is impossible, from its use here, to draw any general conclusions concerning the right to health.

Consideration of health throughout the treaty is based on Article 12 of the ICESCR but predominantly focuses on access to health care and more particularly family planning and reproductive services. This is because it is an area of particular concern to women and one vulnerable to issues of discrimination. However, the specific detail elaborated on in the treaty provides not only a clearer picture of what is meant by a right to access to reproductive health services specifically but also an understanding of what could be considered appropriate health care, more generally. Using a medical model, an 'adequate' system of care is envisaged, means tested where appropriate, that provides on-going support. This would include assessment and monitoring to detect potential problems as well as follow-up care to minimise possible complications and palliative care.

Committee on the Elimination of All Forms of Discrimination Against Women

In a similar manner to the Committee for Economic, Social and Cultural Rights, the Committee on the Elimination of All Forms of Discrimination Against Women uses the policy of adopting 'general recommendations' as well as evaluating state reports. It had already made recommendations concerning issues pertaining to the right to health such as violence against women,[76] female circumcision,[77] discrimination against women in the field of AIDS,[78] and the position of handicapped women.[79] These subjects again feature strongly in its General Recommendation on Women and Health, which focuses predominantly on the right to health care,[80] the socio-economic impact of women's health,[81] and discrimination in relation to health.[82] There is surprisingly no attention given to environmental health and limited consideration of occupational health,[83] drug and alcohol abuse,[84] and mental health.[85] The limited

[76] General recommendation No. 12 (Eighth session, 1989, UN Doc. A/43/38 (violence in general) General recommendation No. 19 (Eleventh session, 1992, UN Doc. A/47/38) (gender-based violence).
[77] General recommendation No. 14 (Ninth session, 1990, UN Doc. A/45/38).
[78] General recommendation No. 15 (Ninth session, 1990, UN Doc. A/45/38).
[79] General recommendation No. 18 (Tenth session, 1991, UN Doc. A/46/38).
[80] CEDAW General recommendation No. 24, paras. 13,14, 21, 22, & 24.
[81] Ibid., paras. 10,12, & 25.
[82] Ibid., paras. 9, 11, 18,& 19.
[83] Ibid., para. 28. Reference is made to Article 11, which is concerned with health and safety in working conditions.
[84] No specific reference is made to drug and alcohol abuse in the recommendation on 'women and health'.
[85] CEDAW General recommendation No. 24, para. 25.

perspective on the right to health is clearly illustrated by the recommendations it makes for government action (Article 31) which are to:

a) Place a gender perspective at the centre of policies and programmes affecting women's health...
b) Ensure the removal of all barrier to women's access to health services, educational and information, including in the area of sexual and reproductive health...
c) Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance...
d) Monitor the provision to women by public, non-governmental and private organizations, to ensure equal access and quality of care;
e) Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;
f) Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence.

The obligations on State parties to respect, protect and fulfil women's right to health were expounded but only in relation to health care. The obligations on State parties are more narrowly defined as they are limited to the specific focus of the treaty. The General Recommendation on Women and Health is important because it is the first formal conceptualisation of the right to health by a treaty body and is particularly important for clarifying the role of non-discrimination as it relates to the right to health. However, much of its content has since been incorporated in the broader General Comment on the Right to Health adopted by the Committee on Economic, Social and Cultural Rights.[86]

Convention on the Rights of the Child[87]

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right, and in particular, shall take appropriate measures:

a) to diminish infant and child mortality;
b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
c) to combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
d) to ensure appropriate prenatal and post-natal health care for mothers;
e) to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
f) To develop preventive health care, guidance for parents and family planning education and services.

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[86] See chapter 3 for analysis and annex II for the full text.
[87] Adopted Nov. 20, 1989, entered into force on Sept. 2, 1990, G.A Res. 44 25, 44 UN GOAR, Supp. (No.49), UN Doc. A/44 49, at 166 (1989), reprinted in 28 ILM 1448 (1989).

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Within the human rights system, society is considered to have a particular obligation to children because childhood is 'entitled to special care and assistance'. However, the standard of health provided for is the same as in the ICESCR except that there is no separation of health into its physical and mental components. The concept of the right to access to health care is considered to be broader than the mere provision of medical care as distinction is made between 'treatment of illness' and 'the rehabilitation of health'. [88] Use of these phrases suggests an intention to assert a right that not only incorporates medical rehabilitation but also a right to assistance in recovery from external forces that impact upon a child's health. This could cover psychological adjustments as well as issues of environmental and social effects on health.

Article 24.2 provides 'appropriate measures' to ensure the protection of the child's rights. This is not a list of specific indicators. It highlights areas of priority concern and establishes loose goals of outcome. But no direction is provided as to how these goals are to be attained and the proposed outcomes are too vague to be useful. A clear baseline figure needs to be established for the minimum acceptable rate of infant and child mortality otherwise, it is difficult to assess potential violations. Similarly, how is one to ensure 'necessary medical assistance and health care'? By contrast, the provisions of Article 24.2(e) and (f) more clearly express the State parties obligation so that failure to address these issues would be in violation of the right to health and the treaty. The treaty goes on to tackle the issue of adverse cultural practices. In so doing, the assertion is made that the health of the child is of higher priority than the cultural practices of the society in which the child lives. This would suggest there is a hierarchy of rights and the right to health has greater import.

[88] During the drafting of this article the United States delegate was willing to accept the concept of the 'right to health' but not the right to 'health care,' thus suggesting that the right to health did not encompass a right to health care.
Leary, V. (1993): 'Implications of a right to health' in Mahoney, K. and Mahoney, P. (eds.) Human rights in the twenty first century : a global challenge, p.486.
But this final draft clearly incorporates the right to health care into the right to health.

It is also important to note that this is the first human rights treaty to specify a legal obligation on State parties to co-operate on health issues. "Enjoyment of the highest attainable standard of health" is not possible without mutual support, which includes financial and technological support as well as the pooling of data and scientific information. Needs vary between states and this treaty provides that particular attention be given to the needs of 'developing countries'. Emphasis on the importance of prevention through the dissemination of information and education is highlighted as a means of empowering the individual to protect his or her own right to health. However, a distinction is made between the rights of a child and the rights of a mentally or physically disabled child. Article 23 attempts to provide the essential minimum to protect and provide for the rights of a disabled child. It establishes a range of rights within a right such that the weakest, most vulnerable sections of the community are afforded a higher standard of the right.[89]

Committee on the Rights of the Child[90]

Because this is a relatively new body, it has not as yet issued any general comments or recommendations. It has, however, released General Guidelines as to the required form and content of initial state reports. Issues most frequently considered include health care policies, the distribution between regions, the quality of health personnel, the adoption of primary health care, family planning policies, infant mortality rates, mental health and traumas due to armed conflict, HIV/AIDS, harmful traditional practices, malnutrition, environmental health, and access to water and sanitation.[91] The work of the Committee on Economic, Social and Cultural Rights would seem to have influenced the approach adopted by the Committee on the Rights of the Child. With a mandate to protect children, the Committee focuses on the vulnerability of children and is particularly concerned to highlight minorities and indigenous children, refugees, displaced persons, illegally residing and unregistered children, and disabled children. As yet, it is difficult to discern whether the Committee on the Rights of the Child has a consistent and comprehensive approach to the right to health. Again, there would be benefit in a closer working relationship with the WHO and, at last, there seems to be positive movement in this direction. In January 1998, the WHO organised a comprehensive briefing to the Committee, which provided the opportunity for each to re-acquaint themselves with the others work and to explore further means of collaboration at multilateral and national

[89] The very notion of needing CRC, CEDAW and the CERD supports such a hypothesis.
[90] Established under Article 24 of CRC.

levels. Since then, the WHO co-ordinated the preparation of commentaries on the health components of initial and periodic reports of 12 States parties to the Convention and presented and interpreted these commentaries to the Committee.[92]

Also within the UN human rights framework are the UN Commission on Human Rights and its Sub-Commission on Prevention of Discrimination and Protection of Minorities.

The United Nations Commission on Human Rights

The UN Commission on Human Rights, directly and indirectly via its Sub-Commission on Prevention of Discrimination and Protection of Minorities, has been concerned with issues emanating from the right to health. In particular, through resolution 1989/11, the Commission expressed concern at the level of discriminatory practices it considered incompatible with medical ethics and human rights. It re-affirmed the right of everyone to the enjoyment of the highest attainable standards of physical and mental care and recalled that all human rights must apply to all patients without exception and that non-discrimination in the field of health should apply to all people and in all circumstances. While this remains a general statement, it does reiterate that the principle of non-discrimination pervades all elements of the right to health. Should the Commission on Human Rights decide to investigate alleged violations of the right to health in more detail, it has the power to do so and may consider it appropriate to appoint a rapporteur to examine the broader issues emanating from the right.

The Sub-Commission on Prevention of Discrimination and Protection of Minorities

In 1980, this Sub-Commission began to develop guidelines for the protection of the mentally ill, and this eventually resulted in the adoption of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care by the General Assembly in 1991.[93] These Principles embody safeguards for 'a right to be different,' by affirming that "non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community shall never be a determining factor

[91] Toebes (1999), pp.150-151.
[92] 52nd WHA, April 1999, Official Records A52/26, 'Collaboration within the UN system and with other intergovernmental organizations: Report by the Secretariat.'
[93] Annex to UN General Assembly resolution 46/119 of 17 December 1991.

in diagnosing mental illness".[94] Such practice must be considered a flagrant breach of the individual's right to health. The Sub-Commission designated experts in conjunction with UNESCO and the WHO to study the phenomenon of traditional practices affecting the health of women and children. The submitted report to the Commission on Human Rights accorded priority consideration to such practices as a) female circumcision, b) preferential treatment for male children, and c) traditional birth practices.[95] These practices were also considered to severely impact the individual's enjoyment of their right to health although a more comprehensive list of adverse practices was included.[96] The assumption must be made that in accordance with the right to health such practices amount to gross violations.

## 2. Regional human rights treaties

European Social Charter[97]

The European Convention for the Protection of Human Rights and Fundamental Freedoms[98]and its Protocols do not include reference to the right to health or health issues generally and the European Social Charter merely acknowledges a 'right to the protection of health'.[99] This suggests a cautious approach to the right to health.[100] Nevertheless, it does not merely reinforce the medical model of health. Health promotion, health prevention, and access to health care are all touched on, but interestingly, the Charter recognises that State parties may meet these obligations with the co-operation of public or private

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[94] 'Principles and guarantees for the protection of mentally ill persons, Report of the Sessional Working Group on the question of persons detained on the grounds of mental ill-health or suffering from mental disorder', UN Doc. E/CN.4/Sub.2/1988/23 of 26 August 1988, Article 6, para. 4.

[95] UN Doc. E/CN.4/1986/42.

[96] This list considered female circumcision, other forms of mutilation, forced feeding, early marriage and adolescent child-bearing, taboos or practices or attitudes preventing women from controlling their own fertility, nutritional taboos and differential feeding patterns, traditional birth practices, and preference for male children.

[97] Adopted by the Committee of Ministers of the Council of Europe on July 6, 1961.

[98] Nov. 4, 1950, 312 UNTS 221 (entered into force Sept. 3, 1953).

[99] Article 11 *The right to protection of health*
With a view to ensuring the effective exercise of the right to protection of health, the contracting parties undertake, either directly or in co-operation with public or private organizations, to take appropriate measures designed *inter alia*:
1. to remove as far as possible the cause of ill-health
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health
3. to prevent as far as possible epidemic, endemic and other diseases.

Clause 11 of the Preamble of the Social Charter states in respect to the right to health care, that "[e]veryone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable."
Roscam Abbing, H. (1979): International organizations in Europe and the right to health care, at p. 77-78. In this book Roscam Abbing goes on to trace the development of Article 11 at pp. 77-83.

organisations.[101] There is no attempt to promote an obligation towards free health care or to impose a particular system of health. In addition, there is also the notion of 'individual responsibility'. Previous international treaties have focused on the duties and obligations of State parties to individuals and vulnerable, minority groups. Here, the individual has a responsibility to consider the health information made available to her or him. This suggests the individual does not have a passive role in the protection and promotion of his or her right to health.

African Charter on Human and Peoples' Rights[102]

The language used in Article 16.1 is very similar to that in the ICESCR except that the standard to be obtained is the 'best' rather than the 'highest'. This lower standard may be in recognition of the difficulties African State Parties face in attaining even this standard with such a high level of poverty and minimal resources. While the standard may be considered more realistic, it remains within a similar range as those already prescribed in other treaties and merely emphasises the crucial role of international co-operation and support if an international right to health is to be attained globally. The emphasis, however, in this treaty remains based on the medical model as the focus is on medical care with health prevention.

Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights - 'Protocol of San Salvador' (1988)[103]

Article 10 Right to Health
1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.
2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure the right:
a) Primary health care, that is, essential health care made available to all individuals and families in the community;
b) Extension of the benefits of health services to all individuals subject to the State's jurisdiction;
c) Universal immunization against the principal infectious diseases;
d) Prevention and treatment of endemic, occupational and other diseases;
e) Education of the population on the prevention and treatment of health problems, and
f) Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

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[100] Jamar (1994), p.32.
[101] Most of the obligations considered as necessary to ensure 'the effective exercise' of this right contain a broad reservation providing State parties with discretionary powers. The exception to this being the requirement to provide advisory and educational facilities - hardly an onerous task.
[102] Adopted June 27 1981, entered into force Oct. 21, 1986, OAU Doc. CAB/LEG/67/3 Rev.5, reprinted in 21 ILM 58 (1982).
Article 16
1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.
[103] Adopted Nov. 17, not in force, OASTS 69, reprinted in 28 ILM 156 (1989).

In contrast to the other regional treaties, the 'Protocol of San Salvador' is progressive, precise and explicit in its recognition of the right to health. Admittedly, this treaty was drafted much later than those already considered and there was no mention of such a right in the earlier American Convention on Human Rights, 1969. Still, there is an unequivocal endorsement of the right to health in the 'Protocol of San Salvador'.[104]

Article 11 does identify features essential to 'ensure' the right to health. The majority of the elements listed are traditional public health measures with an emphasis on access to health care, but there are some interesting features. The influence of the WHO can again be seen with the stipulation of primary health care as a necessary component of the right to health and with the emphasis on education as an important tool to prevent health problems.[105] Of particular interest is the identification of high-risk groups and the poor as having high-priority health needs. This suggests the right to health is not merely an individual's right, which needs to be protected and enhanced, but it also has a community dimension. [106]

**C. Interpretations of the concept: a right to health**

International conferences provide a semi-official forum in which the international community can reflect on a particular issue and establish a consensual policy direction. However, these conferences can also be the stage for intense lobbying and political influence that can result in a compromised final document. Still, this will often be the most recent and comprehensive debate on the assigned topic. Although not legally binding, the final document can greatly impact international and state practice. It is also an opportunity, within the UN system, for non-government organisations and public participation, more generally, to influence international policy and the accompanying media coverage ensures broad exposure. Although, to date, there has not been a UN conference solely on issues emanating from the right to health, there have been several major conferences that considered issues pertinent to this right. Analysis of these can provide useful insight as to the international community's attitudes and priorities concerning the right

[104] Not merely a right to medical care, a right to health care or a right to access to health care.
[105] However, the definition of primary health care provided for in the treaty is at variance with that advocated by the WHO. For further details of the organisation's policy refer to chapter 4.
[106] The treaties considered here are the main international treaties concerned with health. There are, however, other treaties relating to specific health issues or specific minority groups. It is impossible to analyse all of these in detail here. Examples of recent developments, however, include the Universal Declaration on the Human Genome and Human Rights, adopted by the General Conference of UNESCO,

to health. Of these, the Cairo Summit[107] and Beijing Conference[108] and their respective follow-up sessions have provided the most comprehensive coverage of health in an international forum, but there have also been a number of conferences concerned with sustainable development that have touched on pertinent health issues.

At the same time the term right to health has become a convenient shorthand term used by publicists to express numerous obligations relating to health. This has lead to confusion. Are all these concepts inter-related? Do they simply highlight different components of the whole or are they isolated, competing theories? While there is no agreement on the definition of the term itself, there would appear to by agreement as to many of the parts necessarily integral to the whole. Together the work of the UN conferences and the publicists illustrate the problems and issues that society is facing and the potential impact of the right to health.

**1. <u>The Right to Health Care</u>**

The UN conferences often provide a more detailed definition of the subject under discussion than is found in the international treaties already considered. The definitions pertinent to the right to health were considered earlier in this chapter and build on the WHO's definition of health. The definitions adopted focus attention on the 'emotional, social and physical well-being' that is to be determined by the "social, political and economic contest of their lives, as well as by biology."[109] A principle focus of the conferences, in their consideration of health issues, remains directed towards the right to health care.

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11 November 1997 and the European Convention on Human Rights and Biomedicine, signed by Member States of the Council of Europe, on 4th April 1997.

[107] Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994.
As a follow-up there was the Twenty-first special session of the UN General Assembly, overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development, 'Report of the Ad Hoc Committee of the whole of the Twenty-first special session of the General Assembly,' 1999, A/s-21/5 Add.1

[108] Beijing Declaration and the Platform for Action, Fourth Conference on Women. Beijing, China 4-15 September 1995, United Nations, New York, 1996.
As a follow-up there was the United Nations Report of the Ad Hoc Committee of the Whole of the twenty-third special session of the General Assembly, General Assembly Official Records A/S-23/10/Rev.1, June 2000, 'Women 2000: Gender Equality, Development and Peace for the Twenty-first Century.'

[109] Article 91 of the Beijing Declaration.

In most industrialised democracies, universal access to basic health services is assured as a matter of public policy, even though in practice many countries fail to achieve that objective.[110] While some may dispute the accuracy of the statement, it strongly suggests that in theory, at least, the majority of states recognise the right to health care as a social good. In some states, it is also a constitutional right.[111] Yet, there is no definitive interpretation of the term right to health care, and there is even some dispute as to its relationship with the right to health. During negotiations concerned with the drafting of the article focusing on health in the CRC, the United States delegate was prepared to accept the concept of the 'right to health' but not the 'right to health care'. Such a stance could suggest that the right to health be deemed not to encompass a right to health care.[112] There may be political and /or economic considerations that effected this preference for a broader principle. But, there could also have been concern to avoid focusing solely on health care. Indeed, the concept of a right to health care is often viewed as synonymous with a right to medical care.

The right to health care concerns an individual's right to access, within reason, to necessary facilities and services for diagnosis, treatment, care, and prevention of disease.[113] This must, therefore, place a corresponding obligation on the state to ensure the availability of sufficient, effective facilities.[114] There will be broad disparities when the meagre essential services made available in some developing countries are compared to the comprehensive range of services, elaborately equipped hospitals and access to costly methods of treatment available in developed countries. Both the Cairo Summit and the Beijing Conference stress the importance of affordable, accessible and acceptable health care services throughout the life

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[110] Churchill, L. (1994): 'Aligning rights and responsibilities' in Chapman, A. (ed.) Health care reform: a human rights approach, at p.140.

[111] See Fuenzalida-Puelma, L. and Connor, S. (eds.) (1989): Right to health in the Americas: a comparative constitutional study for a detailed description of the various constitutional provisions in the Americas relating to the right to health care;
and Toebes, B. (1999): The right to health as a human right in international law, pp.79-83.

[112] Certainly, this is the view that Leary takes in 'Implications of a right to health' in Mahoney, K. and Mahoney, P. (eds.) Human rights in the twenty first century : a global challenge, at p.486.

[113] "But a right to health care could never be construed to mean the delivery of the highest possible health care on an individual level." Fuenzalida-Puelma and Connor (1989), p.599.

[114] To function effectively this approach to the right to health care requires some clear definitions to be established for need, equitable and access.
Churchill suggests :-
a 'needs' based approach meaning equitable access to be based on need alone to all effective care society can reasonably afford;
'equitable' to signify proportionality as opposed to simple numerical equality. (Needs may drastically vary among people so that a policy of strictly equal access could not be considered equitable.)
The term 'access' to be limited to 'effective care' thereby limiting useless treatments and / or duplicative testing as well as restricting high-tech interventions of marginal utility.
[See Churchill (1994), p.141.]

cycle[115] with the emphasis on primary health care services including sexual and reproductive health care, family planning information and services, and maternal and emergency obstetric care.[116]

Since no detailed discussion took place or proposal was made at any UN conference as to how affordable health care services were to be attained, the presumption must be that states have broad discretion as to implementation providing the system of health care adopted services the entire population. To date there has been no attempt, within the international conference system, to establish a baseline minimum national expenditure on health care services.[117]

The international community has expressed concern to ensure accessible health care not only in relation to equality of availability but also geographical non-discrimination[118] and unrestricted dissemination of information to make informed decisions possible.[119] (With the corollary to universal access to health care being individual confidentiality.) The Cairo Summit focused on the vulnerability of migrants and displaced persons (Article 7.11), adolescents (Article 7.45), and those infected with HIV/AIDS or other sexually transmitted diseases (Article 7.30) whereas the Beijing Conference was more concerned with the issues of women and girls. A general conclusion must be that health care should be made available to all but with a more onerous responsibility on the state to ensure access to the more vulnerable sections of the community. Of equal importance, however, is the obligation to protect individuals from unnecessary

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[115] Cairo Summit Articles 7.5 & 7.23 and from the Beijing Conference see Articles 92 &107(e). This commitment was reaffirmed at the World Summit on Social Development and beyond, July 2000. (Follow-up to the Copenhagen Conference on Social Development, 1995). In its final outcome document on 'Proposals for further initiatives for social development', Commitment 6 particularly encourages universal access to primary health care.

[116] Article 107(e) from the Beijing Conference.
The Commission on the Status of Women reviewed the Platform for Action, Section C: Women and Health and recommended faster implementation of its five objectives. The others being:

- to strengthen preventive programmes that promote women's health;
- to undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues;
- to promote research and disseminate information on women's health;
- to increase resources and monitor follow-up for women's health.

[The Commission on the Status of Women, forty-third session (1-19 March 1999, New York).]

[117] This could be expressed as a percentage of GNP but with the inclusion of international financial support for least-developed countries as necessary.

[118] Ensuring that health services are available within a reasonable and practicable distance and that there is no major disparity between rural and urban services. See Articles 103 & 104 from the Beijing Declaration.

[119] Real decisions can only be made when provided with accurate, appropriate and comprehensible information so that options can be discussed and considered. See Articles 7.32, 7.36 & 7.47 from the Cairo Summit.

surgical intervention and inappropriate medication.[120] But no specific quantitative standards had been established until the follow-up session to the Cairo Summit when new benchmarks were recommended:

i) By 2005, 60 per cent of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods to prevent infection; 80 per cent of facilities should offer such services by 2010, and all should do so by 2015;[121]

ii) At least 40 per cent of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80 per cent globally, by 2005; these figures should be 50 and 80 per cent respectively, by 2010; and 60 and 90 per cent by 2015;[122]

iii) The gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2005, by 75 per cent by 2010, and by 100 per cent by 2015.[123]

Acceptable health care refers to the need for qualitative controls to ensure each person has access to a reasonable standard of care. Even when it is only possible to provide for basic health care needs, the services offered need to reflect the highest standard of medical services available.[124] This means ensuring that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards aimed at ensuring an individual's responsible, voluntary and informed consent.[125] More recently, it has been recognised that the globalisation process resulted in policy shifts that have had a detrimental impact on provision of health services and globalisation has also led to the 'feminization of poverty,'[126] which raises more questions in relation to the notion of acceptability in health care.

It was recognised at the twenty-third special session of the UN General Assembly in June 2000, the follow-up to the Beijing Conference on Women, that the absence of a holistic approach to health and health care for women and girls had constrained progress towards full enjoyment of the highest attainable standard of physical and mental health throughout the life cycle.[127] To achieve a more holistic approach it

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[120] See Articles 103 from the Beijing Conference.
[121] Twenty-first special session of the UN General Assembly, section IV, A.53.
[122] Ibid., section IV, C.64
[123] Ibid., section IV, B.58
[124] Basic health resources are considered to include primary health services for the prevention and treatment of childhood diseases, malnutrition, anaemia, diarrhoeal diseases, communicable diseases, malaria and other tropical diseases and tuberculosis among others. But also services to protect and promote health as well as provide emergency services. (See Article 92 from the Beijing Conference.)
[125] Article 107(g) from the Beijing Conference.
[126] UN Report of the Ad Hoc Committee of the whole of the twenty-third special session of the General Assembly, General Assembly Official Records A/S-23/10 Rev.1, June 2000, p.19, para. 35.
[127] A holistic model of health considers health in a social context: as a human capacity to cope with the environment and everyday life. It requires an intersectoral approach to health that considers the social,

was advocated that more attention be given to the role of social and economic determinants of health and that there should be a shift away from the "predominant focus of health-care systems on treating illness rather than maintaining optimal health...".[128] This holistic approach was advocated to respond to all forms of violence and abuse against girls and women.[129]

One categorisation of the field subject to protection in the matter of health care would be:[130]

1) the right to demand protection against external risks likely to endanger health;[131] 2) the right to demand the organisation and availability of adequate health services and access to medical care;[132] and 3) the right to demand security and hygiene in professional activities.[133] This expands on the simple right to medical care, but academics will seek to further limit these rights by using language such as affordable, balancing or competing rights. Because health care needs to be balanced with education, housing, social services and highways etc.,[134] it may be inalienable but it is not absolute.[135] There are no guarantees of universal access to all care only a decent minimum. The fear is of unlimited legal entitlement and the corresponding costs that would be incurred.

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economic, political, environmental, cultural and spiritual frameworks of society as major determinants of health.

As against the medical model, which focuses on a disease-oriented approach by directing emphasis towards understanding, preventing or curing a single disease and therefore requiring a great deal of technical and medical expertise. By so doing, this approach fails to address the social or cultural components of illness and health.

[128] Ibid., p.10.

[129] Ibid., p.28, para. 69 (i), (j) and (k).

[130] Expounded by F. Wolf as part of discussion in von Wartburg, W. (1979): 'A right to health? Aspects of constitutional law and administrative practice' in Dupuy, R.(ed.) The right to health as a human right, p.144.

While the definition used here was given in relation to health rather than health care *per se* it is an interesting extension that could easily be categorised as within the realm of the right to health care.

[131] States have long recognised an obligation to protect their population from obvious hazards to their health. The issue of health protection will be discussed in more detail later in this chapter.

[132] This is generally expressed in terms similar to those used at the Beijing Conference i.e. accessible, affordable and acceptable care.

For Fuenzalida-Puelma & Connor (1989):

> "...the most useful attempt to define a minimum, humanitarian level of health care below which a society should not morally fall, is the goal of Health for All in the Year 2000, based on a governmental obligation to provide or finance "primary health care"."

[133] The issue of security must necessarily include protection from external injury but also prevention of unethical, non-consensual or violent treatment.

[134] On a broad interpretation of health, these can also be considered as legitimate health concerns. Action taken in all of these areas will certainly impact directly or indirectly on an individual's health.

[135] Churchill (1994), p.142.

Roemer views health care as encompassing a comprehensive range of services: protective environmental services, prevention and health promotion, therapeutic services, and rehabilitative measures.[136] Neither is health protection limited to medical interventions nor even medical interventions combined with health promotion. Related actions in sanitation, environmental engineering, housing, urban planning, agriculture, education and social welfare directly affect health and are increasingly viewed as a social responsibility. While this holistic or maximalist approach appeals to the intellect, it must both alarm and excite lawyers. The array of potential legal entitlement is disconcerting. It is, however, important to differentiate individual entitlement from state obligation. Whether directly or indirectly, the state has long acted on its obligations, in all of these fields although the impact on health may only have been tacitly acknowledged. The shift is to have health issues considered seriously when policy is being determined as well as monitored and assessed. This requires co-operation and co-ordination at local, national, regional and international levels and whether to ensure a right to health care or a right to health it does need to be comprehensively addressed.

A Commission established by the President of the United States in 1993 determined there was a societal obligation to ensure an adequate level of healthcare that is, "enough care to achieve sufficient welfare, opportunity, information, and evidence of interpersonal concern to facilitate a reasonably full and satisfying life."[137] The Commission did not attempt to define an 'adequate level' of health care, preferring to develop criteria that should inform a *public debate* to determine the specific content. The notion of 'adequacy' would be relative to the individual's condition but also limited by the overall benefits and burdens of potential goods and services.[138] This report, in fact, advocates enlarging the Oregon experiment by introducing national public debate and public participation into a process that so far has remained the responsibility of the political state at one end and the medical practitioner at the other.[139] It can also be seen

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[136] Roemer, R. (1989): 'The right to health care' in Fuenzalida-Puelma and Connor (eds.) Right to health in the Americas : a comparative constitutional study, pp. 17-23, p.17.
[137] Brock, D. (1994): 'The President's Commission on the right to health care' in Chapman, A. (ed.) Health care reform: a human rights approach, p.66.
[138] Ibid., p.68.
[139] The Oregon Health Plan was an attempt to incorporate public participation into the decision-making process that was to determine health service allocation. "Oregon has interfaced with the public, experts and the legislature in a content neutral manner in the blending of medical fact and public values to from public policy."
Sipes-Metzler, P. (1994): 'Oregon health plan: ration or reason.' Vol.19 The journal of medicine and philosophy, pp.305-313, p.313.
For further analysis of the Oregon experiment see:

as part of a shift away from the medical model of health to the recognition that health is largely a product of human construction.[140]

**2. Right to healthy conditions or right to health status**

The phrase 'right to healthy conditions' was adopted by Fuenzalida-Puelma & Connor to categorise external factors that impact on the health of society yet are outside the individual's direct realm of influence.[141] Leary, however, preferred to use the term 'right to health status' to indicate that the health of the individual is dependent on factors other than those embodied in the right to health care. [142] Both approaches are concerned with the same social and environmental elements, but the ultimate consideration in terms of the impact on the right to health is different and needs to be considered separately. These social and environmental elements have been categorised as issues of public health: the purity and cleanliness of water and air and the disposal of waste;[143] adequate living conditions which raises issues around housing, a safe environment (at home and work) as well as transport; and the safety and availability of food, drugs, cosmetics and are factors that can impact on the health of the broader community but also on the individual. The use of medical technology and the impact of genetic manipulation would be more recent additions to this list.

"These health conditions affect the entire society; they are public rights, a public good, unrelated to the condition or vicissitudes of a particular individual."[144] This approach could be misleading. The external environmental factors listed above predominantly concern the local community or broader society, but they still impact on some if not all individuals. The emphasis on the public good negates the role that

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Hall, M, (1994): 'The problem with rule-based rationing'. Vol.19 The journal of medicine and philosophy, pp.315-332;
Fleck, L. (1994): 'Just caring: Oregon, health care rationing, and informed democratic deliberation.' Vol.19 The journal of medicine and philosophy, pp.367-388; and
Nelson, J. (1994): 'Publicity and pricelessness: grassroots decisionmaking and justice in rationing.' Vol.19 The journal of medicine and philosophy, pp.333-342.

[140] This is not to imply that it is simply a matter of individual construction.

[141] Fuenzalida-Puelma and Connor, S. (1989).
In this book, the editors advocate adoption of the phraseology 'right to health protection', incorporating a 'right to health care' and a 'right to healthy conditions' instead of the 'right to health'. Their reasoning being that the term right to health may be "incomplete and conceptually misleading". However, in the end they returned to using the 'right to health' for "the sake of convenience and to conform to standard usage in human rights texts..." (p.600).

[142] Leary, V. (1994): 'Defining the right to health care' in Chapman, A. (ed.) Health care reform: a human rights approach.

[143] This includes human, industrial and toxic waste.

individuals have to affect their personal environment. It seems to invoke a paternalistic or utilitarian approach to health conditions rather than a participatory one. A medical condition can be used to obtain the necessary *locus standi* to bring a court action to obtain damages or other relief from external damage such as passive smoking, chemical spills and water contamination. Individuals or groups of individuals also have the power to affect their local environment by participating in public debates such as planning tribunals and demonstrations.

Leary's approach, on the other hand, maintains as paramount the dignity and life of the individual. "By encompassing health status it emphasises that the health of individuals depends on factors such as adequate nutrition, clean water, adequate living conditions as well as on the provision of medical care." The obligation is, therefore, to prevent harm rather than proportion health as another commodity to be allocated solely by market forces. This would seem to be an approach much more in keeping with the human rights ethos. The importance of this distinction becomes clearer when one considers the identification, control, and treatment of infectious diseases, long established as concerns for public health. Recent developments in relation to HIV/AIDS have refocused the public health approach to infectious diseases. [145] The issue of infectious diseases bridges the gap between these external health concerns and the right to health care. The concern is with medical problems that have a profound effect on individuals, communities, states and regions. Certainly, in the case of HIV/AIDS, containment implies modifications to individual behaviour patterns as well as broader community prevention measures.

Whether one prefers the term healthy conditions or health status, there seems to be agreement that the right to health has two elements. The first relates to the right to health care and the second with the impact of

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[144] Fuenzalida-Puelma and Connor (1989), p.599.
[145] Indeed, activities in these areas were the origins of international health co-operation with the International Sanitary Conferences (1851-1903) and the drafting of the various Sanitary Conventions.

broader environmental, social and political factors on the individual, in some measure.[146] Less clear are the duties,[147] obligations[148] and rights[149] as they pertain to the various parties.

### 3. Human flourishing[150]

Generally, the possibility of controlling health and illness is subsumed by clinically or epidemiologically ascertainable answers. This circumvents the anthropological approach that is more concerned with its cultural and societal aspects. Yamin advocates developing the notion of health in terms of 'human flourishing,' thereby moving towards the 'highest attainable standard of *control over* health'.

> "This allows the legal and health professions to transcend entrenched debates by making explicit the dynamics of power in health. By requiring an examination of combinations of power in society that both produce and distribute disease, this approach offers the best hope for anticipating potential ways for people to remake themselves as healthy human beings."[151]

Once health is considered in terms of empowerment, not allocation of resources, the relevant question becomes what is required for an individual or a group to achieve the greatest possible control over her/his health.[152] For "people can be empowered to promote, preserve, and ultimately define their own health status."[153] This is an extremely exciting and important development in the right to health care, because it moves the debate away from simple statistics and accounting. The maximalist and minimalist approaches to health care, in many ways, are simply concerned with the allocation of scarce resources and give the impression that health is simply a commodity. I would concur with Cook when she suggests that:

> "[i]f international human rights law is to be truly universal, it has to be applied both to require States to take effective preventive and curative measures to protect women's health and to afford

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i) right to health care + right to healthy conditions = right to health protection or right to health
or
ii) right to health care + right to health status = right to health
These equations do in fact have much the same content. The emphasis may vary slightly and some academics may debate the minutia but on the whole there does seem to be broad consensus on the principle components of the 'right to health'.

147 Here, using the word 'duty' to mean behaviour due to a binding moral force of what is right.

148 Here, using the word 'obligation' to mean a binding agreement, especially one enforceable under legal penalty, written contract or bond.

149 For the definition of rights refer back to chapter 1.

150 Using 'human flourishing' to mean in the state of complete well-being, as defined by the WHO, in an attempt to move away from the image of human suffering and disease normally associated with health. Yamin, A. (1996): 'Defining questions: situating issues of power in the formulation of a right to health under international law.' Vol.18 Human rights quarterly, pp.398-438, p.437.

151 Ibid., p.438.

152 Ibid., p.407.

153 Ibid., p.414.

> women themselves the capacity, for instance, to achieve their own health and reproductive self-determination."[154]

Access to affordable, acceptable health care remains an important aspect of an individual's right to health but should not be seen as the ultimate goal. By simply focusing on health care, the individual becomes a passive consumer. Empowering the individual to be concerned with the social, cultural and political issues of health beyond the confines of disease leads to a more holistic approach to the right to health and to personal 'flourishing'.

The Cairo Summit and the Beijing Conference, in particular, highlight the integral role of empowerment in the right to health. In order to protect and enhance her or his right to health, an individual has to develop self-esteem or an innate sense of worth as well as acquire knowledge and the ability to function effectively within the developed social structures. It is clear from studying the documents produced at these conferences that there are several important elements pertaining to empowerment and the right to health.

i) *Informed free choice*

True choices can only be made in an environment conducive to informed free choice and the Cairo Summit affirms that "the principle of informed free choice is essential to the long-term success of family planning programmes".[155] This principle extends beyond family planning to all issues of health. Individual have the right to be fully informed of their health options, including likely benefits and potential side effects.[156]

In every society, there are many social and economic incentives and disincentives that effect individual decisions.[157] Health legislation and policy, however, should seek to reflect and enhance the cultural and social diversity of the population rather than channel behaviour.[158] To promote this objective, more women

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[154] The article quoted was concerned principally with women's health but the principle applies to all but especially all vulnerable groups.
[See Cook, R. (1998): 'State accountability for women's health' in Health legislation at the dawn of the XXIst century. Vol.49, No.1 International digest of health legislation, pp.264-282, p.267.]
[155] Article 7.12 from the Cairo Summit.
[156] Article 107(h) from the Beijing Conference – While reference was made specifically to 'women' this principle should apply to all persons and is concerned to formalise as best practice the legal and ethical concept of informed consent.
[157] Article 7.12 from the Cairo Summit.
[158] Beijing Conference, Article 107 (b) and (c).

need to be involved in the leadership, planning, decision-making, management, implementation, organisation and evaluation of health-care systems and services.[159]

ii) *Dissemination of information*

Accurate, clear and comprehensive information is essential if individuals or groups of individuals are to take responsibility for their own health. Article 7.20, from the Cairo Summit, requires governments to remove unnecessary legal, medical, clinical and regulatory barriers to information, particularly related to family-planning services and methods.[160] It was also recognised that to be effective there needed to be a high level of literacy. Recently recommended benchmarks seek to halve the 1990 illiteracy rate by 2005; and by 2010, the net primary school enrolment ratio of both sexes should be at least 90 per cent.[161]

iii) *Right to information*

Literacy, education and the availability of information are important mechanisms to aid in the prevention of discrimination and enable individuals to gain control of their own well being. However, there is an element of social power that operates before people form preferences leading them to accept the existing system as natural, unalterable, divinely ordained or beneficial.[162] Therefore, a necessary component of education needs to be "deconstructing given truths" so people can develop a critical consciousness. Indeed, for Yamin, 'education' must go beyond the deconstruction of repressive practices. It must act in a positive, transformative manner.[163] Development of a critical consciousness involves re-examining the most fundamental assumptions about reproductive health and freedom. Under this theory of empowerment, an individual's entitlement to reproductive rights remains to be personally defined. However, by adopting a

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[159] Article 7.7 from the Cairo Summit.

[160] See also Article 7.3, 7.8 from the Cairo Summit and Articles 107, 108 and 223 from the Beijing Conference.
The importance of equal access to information was again endorsed at the follow-up session to the Beijing Conference.
See UN Report of the Ad Hoc Committee of the whole of the twenty-third special session of the General Assembly, para. 55; and the twenty-fourth special session of the General Assembly: proposals for further initiatives for social development. Further actions and initiatives to implement the commitments made at the Summit, July 2000, p.18.

[161] Twenty-first special session of the UN General Assembly, section II, E.35 (c).

[162] Yamin (1996), p.432.

[163] Ibid., pp. 433-435.
In practice it is difficult to envisage how such a process could be effected, as dissemination of information is rarely a neutral process. Yamin suggests it is possible to develop a "kind of dialectical education," which allows people to internalise an aspirational standard while maintaining a sceptical stance towards its implementation.

more internationally accepted approach to human rights, reproductive rights, as an element of the right to health, give rise to a range of individual entitlements. [164] As discussed earlier, the Cairo Summit asserted the right of the individual to a satisfactory sex life, which implicitly requires having accurate information, access to affordable, safe, effective and acceptable methods of family planning; and appropriate supportive health services. The suggestion that there is a legal entitlement protecting the right to reproductive health is more tenuous, because no specific mention was made of a right to reproductive health in the various treaties.[165] Reproduction, however, is a fundamental aspect of health and a liberal interpretation of Article 25.2 of the Universal Declaration of Human Rights and Article 12.2a of the ICESCR would support such a hypothesis.

iv) *Full participation*

> "Democracy, development and respect for human rights and fundamental freedoms are interdependent and mutually reinforcing. Democracy is based on the freely expressed will of the people to determine their own political, economic, social and cultural systems and their full participation in all aspects of their lives."[166]

The right to 'full participation' is to be exercised at the national, regional and international levels and applied fully and equally to all (including women and the girl-child).[167] The notion of full participation has since expanded to recognise the need to focus on women's conditions and basic needs as well as to adopt "a holistic approach based on equal rights and partnerships, promotion and protection of all human rights and fundamental freedoms."[168]

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[164] The tendency is to relate reproductive rights to the prevailing concept of reproductive health. For examples refer back to the Cairo Summit and the Beijing Conference.
[165] If one is to adopt a positivist approach.
[166] World Conference on Human Rights – The Vienna Declaration and Programme of Action (1993) in Ghandhi (ed.) (1995) Blackstone's international human rights documents at p.333, para.8.
[167] Ibid., p.335, para.18.
Also see objective IV, Article 4.4 (a) and (g) on Empowerment of Women in the programme from the Cairo Summit.

v) *Development of strategies at a community level*

As part of this right to 'full participation,' governments should promote greater community participation. Communities need to be able to develop strategies responding to local perceptions of health needs.[169] It was felt that this could be achieved, in relation to reproductive health-care services in particular:

> "...by decentralizing the management of public health programmes and by forming partnerships in cooperation with local non-governmental organizations and private health-care providers. All types of non-governmental organizations, including women's groups, trade unions, cooperatives, youth programmes and religious groups, should be encouraged to become involved in the promotion of better reproductive health."[170]

Gender sensitive health programmes would require consideration of women's needs throughout their lives and reflect the multiplicity of their roles and responsibilities.[171]

vi) *Right to protect individual entitlement*

Protection of an individual's entitlement under the right to health requires the individual to have access to a grievance procedure. Such a system should include provision for grievances to be aired, ability to mount challenges to identify unsatisfactory practice, mechanisms to ensure prevention of recurrence of mishaps, adequate compensation for victims of accidents and a system to deter practitioners from allowing standards to slip.[172] All of these provisions, while necessary to ensure protection of an individual's right to health, are only concerned with health care provisions. Redress for negative environmental effects; a system to ensure a voice in relation to community health issues; access to information; and ability to effect urban planning, the work environment, transport, waste disposal etc. also are essential mechanisms to protect an individual's health status under the right to health.

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[168] UN Report of the Ad Hoc Committee of the whole of the twenty-third special session of the General Assembly, p.23, para. 53.

[169] Here concern was specifically being directed at issues associated with the spread of HIV and sexually transmitted diseases but the principle need not be so confined. See Article 8.32 of the Cairo Summit on Population and Development.

[170] Article 7.9 of the Cairo Summit.

[171] UN Report of the Ad Hoc Committee of the whole of the twenty-third special session of the General Assembly, p.29, para. 72 (g).

[172] This list of mechanisms necessary to enforce health care rights was identified by Montgomery (1992), p.102.

The problem, even for an individual's legal entitlement, is the limited system of complaint, protection and enforcement within a democratic legal and political system at national level.[173] At the international level, there are equally limited complaint mechanisms in force. Even in states where the right to health is a constitutional right, it is generally considered to merely place obligations and responsibilities on the state. The best protection for legal entitlement remains access to public debate and public participation at all levels of health policy. Unfortunately, no such comprehensive system is in place at either the state or international level.

## 4. Violations of the right to health

Although many subjects are discussed at the various UN conferences, it is clear from the finally produced documents that there are certain acts or patterns of behaviour that the international community considers completely unacceptable. Such practices are held to violate the essential dignity of the person and as such have a fundamental impact on that person's right to health. As a result, any state condoning these acts must be considered in violation of their obligations to protect the right to health of the people they represent. Similarly, the person or persons performing such acts must be considered in violation of their duty to respect the right to health of others. These include:

i) *Prohibition of female genital mutilation*

Governments agreed to enforce the prohibition of female genital mutilation under the Cairo Programme[174] and the Beijing Platform.[175] Indeed, "[g]overnments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices." To assist in the elimination of such practices, it is recommended that states develop strong outreach programmes involving village and religious leaders, education and counselling about its impact on girls' and women's health, and appropriate treatment and rehabilitation for girls and women who have suffered mutilation. Services should include counselling for women and men to discourage the practice.[176]

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[173] Generally, to utilise the court system for issues of public law an individual is required first to prove sufficient *locus standi*, which seriously restricts access. Court action is thus limited to criminal actions, gross negligence or personal tort actions.
[174] Articles 4.22, 5.5 & 7.40 of the Cairo Summit.
[175] Articles 124 (i) & 283(d) of the Beijing programme.
[176] Article 7.40 of the Cairo Summit.

ii) *Elimination of infanticide and sex selection*

Both the Cairo Summit and the Beijing Conference advocate:

> "[elimination of] all forms of discrimination against the girl child and the root causes of son preference which result in harmful and unethical practices such as female infanticide and prenatal sex selection; this is often compounded by the increasing use of technologies to determine foetal sex, resulting in abortion of female foetuses."[177]

Various measures were considered appropriate to attain this objective, but the primary focus was on special education and public information programmes.[178]

iii) *No role for coercion in health*

A state cannot seek to regulate its population growth by use of coercive measures such as compulsory sterilisation or abortion, or, at the other extreme impose criminal sanctions against contraception, voluntary sterilisation and abortion.[179] Indeed, the Cairo Summit affirmed that "[t]he principle of informed free choice is essential to the long-term success of family-planning programmes. Any form of coercion has no part to play".[180]

iv) *Unrestricted access of adolescents to appropriate services*

Of particular concern was the need to remove legal, regulatory and social barriers to health information and care for adolescents.[181] Such information was not only to concern issues of reproductive health but also, according to Article 7.47 of the Cairo Summit, gender relations and equality, violence against adolescents, family life, responsible family-planning practice and sexually transmitted diseases, HIV infection and AIDS prevention. The Twenty-first special session of the UN General Assembly in 1999 established new benchmarks to reduce the vulnerability of young men and women, aged 15-24 to HIV/AIDS infection. By 2005, 90 per cent of young people should have access to preventive methods such as female and male condoms, voluntary testing, counselling and follow up; and at least 95 per cent by

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[177] Article 277(c) Beijing Conference on Women expands slightly on Article 4.169(a) of the Cairo Summit.
[178] Such programmes would focus on the need "to promote equal treatment of girls and boys with respect to nutrition, health care, education and social, economic and political activity, as well as equitable inheritance rights" (Article 4.17 of programme from the Cairo Summit).
Further details on potential education programmes were provided in Articles 4.18 and 4.19.
[179] Cook, R. (1997): 'Reproductive health law: where next, after Cairo and Beijing?' Vol.16 Medicine and law, pp.169-178, p.172.
[180] Part of Article 7.12 of the programme produced at the Cairo Summit. However, this position was not as emphatically reiterated at the Beijing Conference (see Articles 98, 107 and 108(d)).
[181] See Article 7.45 of the Cairo Summit and Articles 108(a) & (e) of the Beijing Conference.

2010. HIV infection rates in persons 15-24 years of age should be reduced by 25 per cent in most affected countries by 2005 and by 25 per cent globally by 2010.[182]

There are clearly certain areas of particular concern to the international community, and the international conference has been used as the forum to highlight these. States that fail to address the issues of female genital mutilation, infanticide and sex selection or adopt coercive policies on population control are in violation of their obligations but so are states that restrict access to health information. The recommendations as to how states could start to address such violations are not compulsory, but failure to implement any of the recommendations would require a reasoned explanation for a state to avoid censure for being in violation of the right to health.[183] Because such conferences tend to have a narrow focus these cannot be considered a comprehensive list of violations. However, such issues must be considered an integral part of the right to health.

Chapman has formulated a more detailed 'violations' approach to the right to health:[184] Chapman begins with violations of obligations to respect, obligations to protect and obligations related to gender non-discrimination.

**A) Violations of the obligation to respect** are conceptualised as state actions, policies or laws that contravene standards set in the Covenant and that have the direct result of increasing the likelihood of bodily, unnecessary morbidity and premature mortality. They include the following:

1) Government policies and actions which use medicine and health professionals to inflict torture, physical and psychological abuse and death in contravention of international standards...
2) Interference with the provision of health services as a punitive political measure...
3) Deliberate withholding of information vital to health protection or treatment...
4) Public policies that encourage the use of tobacco and the consumption of alcohol and other toxic substances...
5) Coercive birth control practices, including pro-natalist policies, forced abortions, and large-scale sterilizations...
6) Discrimination in the provision of health care as a state policy...
7) Government policies that restrict the reproductive rights of those affected with genetic diseases...

[182] Twenty-first special session of the UN General Assembly, section IV, A.53. 30 June-2 July 1999.
[183] Such violations would come under the remit of a number of the treaty bodies depending on the precise details of the violation to be considered.
[184] Chapman (1998), pp.399-418.

**B) Violations of the obligation to protect**

Based on the Maastrict Guidelines, the obligation to protect requires states to affirmatively prevent persons under its jurisdiction from violations of the Covenant by third parties, which would include:

1) Failure to discourage production, marketing and consumption of cigarettes, alcohol, and drugs...
2) Failure to protect women against violence or prosecute perpetrators...
3) Inadequate environmental protection...
4) Environmental racism...
5) Failure to limit the availability of guns...
6) Failure to prevent discrimination by third parties against AIDS patients...
7) Failure to protect against arbitrary denial of health insurance coverage...
8) Failure to assure the development of health information systems consistent with human rights criteria...

**C) Violations related to gender non-discrimination**. This includes:
1) Failure to respect women's reproductive rights...
2) Failure to grant women true personhood and autonomy...
3) Legalization or policy support for medical or cultural practices that endanger health...
4) Gender bias in Health research
   - to date, health research has been discriminatory on two levels. First, many health problems specifically or particularly affecting women have not received sufficient attention.
   - second, women are rarely included in research trials.
5) Inadequate training of female health care workers
   - In many cultures female doctors and nurses can only treat women.
6) Failure to discourage or prohibit sex selection as a basis for abortion...

For Chapman the minimum core content of the right to health should include:
1) Explicit recognition of a right to health;
2) Establishment of an appropriate institutional framework and a set of policies assuring basic standards of health and promoting progressive realisation of the highest attainable standard of physical and mental health;
3) Allocation of appropriate levels of resources invested in ways that will bring the greatest health benefit to the population;
4) Respect for the equality of all persons;
5) Institution of effective measures to prevent discrimination;
6) Prioritisation of efforts to rectify existing inequities and imbalances in the distribution of resources in the health sector to bring currently undeserved and disadvantaged groups up to mainstream levels;
7) Designation of treatment of health services as a public good rather than a profit-making commodity;
8) Development of a detailed plan, with specific goals, for the progressive realisation of the right to health care; and
9) Monitoring performance and attainment of core goals based on adequate data gathering and analysis capabilities.[185]

Conversely, failure to implement a core minimum of the right to health includes:
1) Failure to recognize or implement a right to health or to health care.
2) Insufficient expenditure or misallocations of public money...
3) Failure to focus government initiatives on rectifying existing imbalances in the provision of health services ...
4) Failure to provide basic obstetric services to make pregnancy and childbirth safe ...
5) Failure to undertake sufficient public health measures to protect against and combat infectious diseases.
6) Failure to cover the eligible population with a package of childhood immunizations...

[185] Chapman (1998), pp.409-414.

Chapman has written a number of interesting and informative articles outlining and advocating a 'violations' approach to the right to health.[186] She believes it may not be possible to definitively establish the right to health, but there are obvious acts or omissions that are generally accepted to be violations of this right. In my view, while such an approach is useful to initially outline the ambit of the right to health, problems arise from simply listing possible violations. It produces a narrow scope to the right with limited potential for development of the right to health. A violations approach presents issues as black and white where actually there is a measure of uncertainty. It also encourages a very negative approach by promoting the notion of conflict rather than partnership. Classification of all aspects of the right to health as violations limits manoeuvrability and the ability to attain the highest standard of health. This is not to suggest that clear violations of the right to health should not be considered as such and appropriate action taken by the international community. My concern is that the issue is less easily categorised.

Toebes sought to build on Chapman's analysis and the work of the Committee on Economic, Social and Cultural Rights. In her book, Toebes seeks to identify the responsibilities on states with regard to health care and underlying preconditions in terms of respect, protection and fulfilment of obligations.[187] In this manner, she attempted to identify the general content of the right to health,[188] as well as what she considers to be its core obligations.[189] Such an approach can benefit human rights bodies that are seeking to monitor

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[186] These include:
Chapman (1998);
(1996): 'A "violations approach" for monitoring the International Covenant on Economic, Social and Cultural Rights.' Vol.18 Human rights quarterly, pp.23-66;
(1995): 'Monitoring women's right to health under the International Covenant on Economic, Social and Cultural Rights'. Vol.44 The American university law review, pp.1157-1175;
(1994): 'A human rights approach to health care reform' in Chapman, A. (ed.) Health care reform: a human rights approach, pp.149-163.

[187] Toebes (1999) in which she utilises the tripartite typology developed by Henry Shue in his 1980 book: Basic rights, subsistence, affluence and U.S. foreign policy.

[188] See the tabulated matrix on pp.314-315 of her book for specific details.

[189] Toebes (1999), pp.336-338.
To comply with the core obligations to **respect** the right to health, states have to:
1. Respect (equal) access to basic health services...
2. Refrain from acts that seriously encroach upon people's health...

To comply with the obligation to **protect** the right to health, states have to:
1. Take legislative and other measures to assure that people have (equal) access to basic health services if provided by third parties...
2. Take (legislative and other) measures to protect people from serious health infringements by third parties...

The obligation to **fulfil** embraces the positive obligation to provide access to basic health services. States have to:

and enforce treaty obligations concerning the right to health. However, there is an inherent danger in focusing solely on core state obligations at the expense of the broader content of the right. Consistently when considering the right to health, the appropriate international standard to be applied is that of the highest attainable in relation to health but if states were to seek to fulfil only the obligations identified by Toebes, this would be undermined although it would be an improvement on the existing situation. The formulation she adopts is particularly useful to gain understanding as to the level of obligation states have in relation to underlying preconditions as they relate to health and health care.

**D. Conclusions**

While the right to health was clearly established as a separate and legally binding right in the ICESCR neither it nor subsequent treaties have provided a detailed understanding of the term. The usage of the terms 'health' and 'right to health,' in international treaties, have been inconsistent and vague. But the fact remains that the right to health is expressly acknowledged as a legally binding right and so cannot simply be dismissed by states as merely a moral obligation.

On close analysis of these international treaties, it is also possible to establish a clearer picture of the position of the right to health within the international human rights framework. Human rights can be viewed as interwoven layers that necessarily interrelate and have a measure of mutual dependency. The right to health must also have a discrete core that distinguishes it from other rights even if the parameters are not distinct. For there is no clear boundary, but rather the right to health gradually fades and connects with such rights as the right to food, the right to housing, and the right to education. Even within this 'discernible' core, there are interconnected layers as the most vulnerable minorities in society are vested with a higher standard of the right to health. Again bold distinctions are impossible to delineate, so it is only possible to have a sense of shade as to the essential spectrum of content.

I conclude that three aspects of the right to health can be identified as enshrined in the international instruments on human rights. These are the declaration of the right to health as a basic human right; the

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1. Adopt a national health policy and devote a sufficient percentage of their budget to health...
2. Provide basic health services or create conditions under which individuals have adequate and sufficient access to health services...
[Emphasis added.]

prescription of standards aimed at meeting the health needs of specific groups of persons; and the prescription of ways and means for implementing the right to health.[190]

i) *Declaration of the right to health as a basic human right*

Within the declaration of health as a basic human right, it is possible to discern several consistent elements. One such element is the right to access medical care and such access must apply equally to all with no discrimination on grounds of sex, race, religion etc. Certainly, the principles of equality and non-discrimination strongly pervade all issues of health and human rights. The right to medical care is, in fact, broadened to become the right to access to health care.

ii) *Prescription of standards aimed at meeting the health needs of specific groups of persons*

Minority groups such as women, children and the disabled have been identified as having specific health needs considered essential to ensuring their right to health. This does not necessarily establish a hierarchy of needs within the right to health itself but could simply be recognition of the individualised nature of health needs. Health needs vary geographically as well and this was reflected in the recognition of cultural and social differences and by the fact that 'developing' countries require assistance to meet their obligations.

iii) *Prescription of ways and means for implementing the right to health*

These international treaties do, however, seek to prescribe some of the ways and means by which the right to health can be attained. The lists provided are not finite, but the ICESCR, CRC and the Protocol of San Salvador provide considerable guidance as to how states should ensure protection of health care and health status among their communities. There is recognition that solutions to health issues transcend national borders and so international co-operation is essential as well as an implied acceptance of the interrelationship and interdependence of the right to health and economic, social, cultural and educational matters.[191]

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[190] Van Boven, T. (1979): 'The right to health' in Dupuy, R. (ed.) The right to health as a human right, at p. 54.

[191] "What is not clearly articulated, however, is that the nature of the political organisation could and does in addition to race, sex, religion and language, constitute the basis of discrimination with respect to the right to health."

What is clear from an examination of these international treaties is that the right to health is not a narrow concept simply limited to demands for medical services or concerned with traditional public health measures. It also incorporates the broader social and physical environments that impact on the health of the individual. UN conferences have adopted this broader approach to issues of international health and have usefully detailed specific aspects of the right to health. However, as there has not yet been a conference concerned with the right to health as its focus, no clear understanding can be gleaned. Most publicists have also tried to expand the notion of the right to health beyond the right to health care. While it is possible to discern a measure of consensus and overlap between some of the approaches advocated, there remain at least four separate theories on the content of the right to health. Each of these theories has merit. The choice of approach depends on whether the underlying aim is to establish clear and enforceable legal obligations on the state or to use the right to health to assist individuals to maximise their potential. These options reflect different positions as to the origins and purpose of human rights. I would suggest that the approaches are not mutually exclusive but just approach the concept from different ends of a continuum. To maximise the development of the right to health may require the coalescing of all these theories.

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Eze, O. (1979): 'Right to health as a human right in Africa' in Dupuy, R. (ed.) The right to health as a human right, at p.81.

# 3
# Established legal obligations in relation to the right to health

An essential step in the development of the right to health has been the conceptualisation of the right within the legal human rights framework. The General Comment by the Committee on Economic, Social and Cultural Rights[1] has been pivotal to gaining an understanding of the current legal obligations under the right to health.[2] As such this is a crucial beginning for the right to health. At last, the necessary building blocks have been established from which the right to health can develop to reach its maximum potential. The initial section of this chapter describes, in detail, the General Comment on the Right to Health. In the second section, I evaluate the effect of the General Comment and in the final section I discuss its limitations.

## A. The General Comment on the Right to Health by the Committee on Economic, Social and Cultural Rights

Firstly, there is a clear recognition in the General Comment on the Right to Health by the Committee on Economic, Social and Cultural Rights of the importance of the right to health:

> "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."[3]

Secondly, it details the broad range of components that combine to establish the notion of a right to health. Some of these components overlap and form an integral relationship with other established human rights such as: "the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement".[4] The implication from this is that the Committee considers that the right to health is not

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[1] UN Committee on Economic, Social and Cultural Rights: The right to the highest attainable standard of health: Comment 14 (General Comments). UN Doc.E/C.12/2000/4.
Reproduced in its entirety in Annex II.

[2] And to a lesser extent the General Comment by the Committee on the Elimination of Discrimination Against Women although most of the obligations are also contained in the General Comment by the Committee on Economic, Social and Cultural Rights.
[ CEDAW General recommendation No. 24, 'Women and health.'(Twentieth session, 1999, UN Doc. A/45/38), Feb.2nd 1999. As discussed in chapter 2. Most of the significant obligations have been reiterated by the Committee on Economic, Social and Cultural Rights.]

[3] General Comment 14, para.1.

[4] Ibid., para. 3.

confined to the right to health care but encompasses those biological and socio-economic determinants that affect the ability of people to lead a 'healthy life.'

It is made clear that the notion of "the highest attainable standard of health" established in article 12.1 of the ICESCR has practical limitations and should rather be understood as a "right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health".[5] But the definition provided in the General Comment on the Right to Health is still broader than a literal interpretation of the first paragraph in Article 12 would have suggested.[6] The examples set out in Article 12 (2) of the ICESCR are considered to provide "specific generic examples of measures arising from the broad definition of the right to health found in paragraph one".[7] The examples merely identify a non-exhaustive list of subgroups that illustrate the content of the right to health and these have been interpreted expansively.

For example, Article 12.2 (a) is concerned with the "reduction of the still birth-rate, infant mortality and the healthy development of the child". However, the General Comment on the Right to Health makes clear that it has been understood to include

> "requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre-and post-natal care, emergency obstetric services and access to information, as well as to resources to act on that information."[8]

In addition, as 'special topics of broad application,' women and the right to health, children and adolescents and a gender perspective have been highlighted.[9] By so doing, the Committee has rectified the implicit deficit of Article 12 to specifically address women's issues.

Similarly, Article12.2 (b) is interpreted to consider the "right to healthy natural and workplace environments" so as to include not just occupational accidents and diseases but broader environmental

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Thereby, drawing attention to other pertinent General Comments by the Committee such as General Comment No. 13 on the Right to Education: 08/12/99. UN Doc. E/C.12/1999/10.
Education has an important role in empowering the individual to protect and affect her/his right to health. Indeed, the first paragraph of the General Comment on Education specifically highlights the importance of this function.

[5] Ibid., para 9.

[6] This is simply a pragmatic realisation that the global health situation has undergone dramatic changes since the ICESCR was first adopted in 1966 and illustrates that the role of the Committee is to interpret the Covenant to meet the current needs of the global society.

[7] General Comment No. 14, para.13.

[8] Ibid., para 14.

[9] Ibid., paras 21, 22 and 20 respectively.

hazards as well as discourage "the abuse of alcohol, and the use of tobacco, drugs and other harmful substances".[10]

The prevention, treatment and control of diseases (article 12.2. (c)), according to the General Comment on the Right to Health requires the development of prevention and education programmes, identifying sexually transmitted diseases as an area of concern; the promotion of the social determinants of good health as well as provision of care in the case of accidents. Disaster relief and humanitarian assistance in emergency situations were also included.[11]

The obligation to assure "medical service and medical attention" as established in article 12.2. (d) of the ICESCR has been interpreted in the General Comment on the Right to Health to be the "right to health facilities, goods and services".[12]

The General Comment on the Right to Health adds to this list broad special topics such as non-discrimination and equal treatment, older persons, persons with disabilities, and indigenous peoples that are considered to warrant specific attention.[13] Within each component identified above, there are four 'interrelated and essential elements' that need to be addressed. These elements are availability, accessibility, acceptability and quality. Availability means that there is sufficient facilities, programmes or resources to provide sufficient quantity to fulfil the needs of the State party concerned; accessibility relates to non-discrimination, physical accessibility, affordability and information accessibility of goods or services provisions; acceptability requires that provisions must be "respectful of medical ethics and culturally appropriate;" and quality refers to meeting scientific and medical standards that are culturally acceptable.[14] Together this interpretation of article 12 of the ICESCR provides a much fuller definition of the right to health.

[10] Ibid., para. 15.
[11] Ibid., para. 16.
[12] Ibid., para. 17.
[13] Ibid., paras. 18-27.

## 1. Obligations on State parties

The Committee on Economic, Social and Cultural Rights in the General Comment on the Right to Health reiterates that, despite the provision for progressive realisation of the rights enshrined in the ICESCR, it does place immediate obligations on state parties in relation to the right to health. These include:

> "the guarantee that the right will be exercised without discrimination of any kind (art.2.2) and the obligation to take steps (art.2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health."[15]

Even progressive realisation has 'meaningful content' in that "States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12".[16]

In relation to general legal obligations on states arising from the right to health, the Committee on Economic, Social and Cultural Rights reiterates in the General Comment on the Right to Health, the principles laid down in its earlier General Comment No. 3 but further establishes that:

> "[t]he right to health, like all human rights, imposes three types or levels of obligations on State parties: the obligations to respect, protect and fulfil. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote."[17]

The obligation to respect is negative in that states are required to refrain from interfering, directly or indirectly, with the enjoyment of the right to health. The obligation to protect requires states to "take measures that prevent third parties from interfering with article 12". The obligation to fulfil outlines appropriate positive acts to be taken in the form of "legislative, administrative, budgetary, judicial, promotional and other measures" to further the realisation of the right to health.[18]

In addition to these generalities, the General Comment on the Right to Health details specific legal obligations in relation to each of these categories to provide states with concrete examples of appropriate and inappropriate conduct under the right to health. Examples of these obligations are provided in relation to the right to health care, the socio-economic factors that promote conditions enabling people to lead a healthy life and the underlying determinants of health.

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[14] Ibid., para. 12.
[15] Ibid., para. 30.
[16] Ibid., para. 31
[17] Ibid., para. 33.
[18] Ibid.

These examples include:

i) *The right to health care*

States are under the obligation to *respect* the right to health by refraining from denying or limiting equal access for all persons to preventive, curative and palliative health services. Strong emphasis was placed on the need to abstain from enforcing discriminatory practices in this regard.[19]

Obligations to *protect* include requiring the states to adopt legislation or to take other measures to ensure equal access to health care and health-related services provided by third parties and to ensure that privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services.[20]

The obligation to *fulfil* requires State parties to give sufficient recognition to the right to health in national political and legal systems as well as to adopt a national health policy with a detailed plan for realising the right to health.[21]

ii) *Socio-economic factors*

States should *respect* the right to health by refraining from preventing people's participation in health-related matters and refrain from censoring, withholding or intentionally misrepresenting health-related information.[22]

In relation to the obligation to *protect* the right to health, states are specifically obliged to ensure that harmful or traditional practices do not interfere with access to pre-and post-natal care and family planning. States are also obliged to prevent the coercion of women to undergo traditional practices such as female genital mutilation.[23]

The obligation to *fulfil* requires states to promote medical research and health education as well as information campaigns particularly with regard to HIV/AIDS, sexual and reproductive health, traditional

[19] Ibid., para. 34.
[20] Ibid., para. 35.
[21] Ibid., para. 36.
[22] Ibid., para. 34.

practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances.[24]

iii) *underlying determinants of health*

States should *respect* the right to health by refraining from unlawfully polluting air, water and soil. An example given was that States should refrain from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health.[25] This suggests that the Committee on Economic, Social and Cultural Rights is adopting a very broad interpretation of underlying determinants of health.

No specific examples are provided of state obligations in relation to the underlying determinants of health but the assumption must be that the state has obligations to adopt legislation or take other measures to *protect* "food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment".[26]

The obligation to *fulfil* requires States parties to ensure equal access for all to the underlying determinants of health, such as nutritiously safe food, and potable drinking water, basic sanitation and adequate housing and living conditions.[27]

As well as a general obligation to *fulfil* the right to health, States have an obligation to *facilitate* (*fulfil*) by taking positive measures that enable and assist individuals and communities to enjoy the right to health. States also have an obligation to *provide* (*fulfil*) in relation to the right to health when, for reasons beyond their control, individuals or groups are unable to realise the right themselves. The obligation to *promote* (*fulfil*) the right to health requires States to undertake actions that "create, maintain and restore the health of the population".[28]

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[23] Ibid., para. 35.
[24] Ibid., para. 36.
[25] Ibid., para. 34.
[26] Ibid., para. 4.
[27] Ibid., para. 36.
[28] Ibid., para. 37.

At the same time, the Committee, in the General Comment on the Right to Health, felt it necessary to use the same categorisation to identify specific acts or omissions that are violations of the right to health.[29] In this way, the Committee is able to emphasise the fundamental components of the right and thereby direct State parties to the essential policy obligations arising in relation to the right to health.

The General Comment on the Right to Health also identifies a minimal level of core obligations in relation to the right to health and then a second set of obligations, which it considers to be of 'comparable priority'.[30] The two lists combined provide a detailed understanding of the minimum obligations of the right to health and the essential provisions for all national health policy.[31] To ensure that all States parties are in a position to meet these core obligations, the Committee on Economic, Social and Cultural Rights emphasises the obligation on State parties to provide international assistance to enable developing countries to fulfil these obligations and the collective responsibility of the international community to assist poorer developing States.[32] By detailing significant and substantial obligations on all State parties, the Committee on Economic, Social and Cultural Rights confirms the importance of the right to health.

The Committee on Economic, Social and Cultural Rights also considers it important to establish a dialogue with State parties as a working relationship is necessary in order to identify measures through which the implementation of the right to health could be effected at the national level. These suggestions include framework legislation, right to health indicators and benchmarks, and remedies and accountability. Through these devices the Committee seeks to influence the manner in which State parties attain the right to health.

**2. <u>Freedoms and entitlements of individuals</u>**

While the majority of the General Comment on the Right to Health is concerned to establish obligations in relation to State parties, it is also made clear that the right to health contains freedoms and entitlements for

[29] Ibid., paras. 46-52.
[30] These core obligations are to be read in conjunction with the Programme of Action of the International Conference on Population and Development (Report of the International Conference on Population and Development, Chapters VII and VIII, Cairo, 5-13 September 1994, A/CONF.171/13/Rev.1, Annex) and the Declaration of Alma-Ata, 1978, and are clearly influenced by the content of these two programmes. For details of the core obligations see General Comment No. 14, para.43 and 44 reproduced in Annex II.
[31] These lists are set out in their entirety in Annex II.
[32] General Comment No. 14, para. 40.

the individual. There are two such freedoms. One is the "right to control one's health and body, including sexual and reproductive freedom".[33] The other is the right to be free from interference, which specifically includes freedom from torture, non-consensual medical treatment and experimentation.[34]

The General Comment on the Right to Health states that "the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[35] One component of such a system is to facilitate the participation of the population in all health-related decision making at the community, national and international levels.[36] An equitable system of participation is to be available in the provision, improvement and furtherance of preventive and curative health services but also in the broader political decision-making at both the community and national levels.[37] The population is to have a voice in the organisation of the broader health sector including the type of insurance system to be adopted.[38]

According to the General Comment on the Right to Health, another component of a system of health protection is the ability of any person or group victim to have access to effective judicial or other appropriate remedies for a violation of the right to health. Appropriate reparation "may take the form of restitution, compensation, satisfaction or guarantees of non-repetition".[39] Independent arbitrators such as national ombudsmen, human rights commissions, consumer forums, patients' rights associations should be utilised to address violations of the right to health.[40]

The General Comment on the Right to Health sets out that a specified element of this entitlement is the development of a system that does not discriminate. Discrimination is proscribed on the basis of

> "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health."[41]

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[33] Ibid., para. 8.
[34] Ibid.
[35] Ibid.
[36] Ibid., para. 11.
[37] Ibid., para. 17.
[38] Ibid.
[39] Ibid., para. 59.
[40] Ibid.
[41] Ibid., para. 18.

Vulnerable groups such as women, children, older persons, persons with disabilities and indigenous peoples are identified as at risk of being discriminated against. The General Comment on the Right to Health calls for adoption of "relatively low-cost targeted programmes" to be adopted as part of a comprehensive strategy to ensure their entitlement is protected.[42]

### 3. Non-state actors

Paragraph 42 of the General Comment on the Right to Health is particularly significant for the development of the right to health. While recognising that only states are parties to the ICESCR, the Committee considers that all members of society have 'responsibilities' with regard to the realisation of the right to health.[43] Specifically mentioned in this regard are individuals, including health professional, families, local communities, intergovernmental and non-governmental organisations, civil society organisations and the private business sector.[44] The obligation on the state is to provide an environment that facilitates the carrying out of these 'responsibilities' by all members of society.[45]

Equally important is the concern on the part of the Committee on Economic, Social and Cultural Rights to require international organisations to protect the right to health. While respecting their individual mandates, a number of international organisations are requested to co-operate more effectively with States parties to assist in the implementation of the right to health at the national level.[46] The World Bank and the International Monetary Fund, in particular, are singled out has having an obligation "to pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes".[47] Furthermore, adoption of a human rights-based approach within their institutions and programmes is advocated for all UN specialised agencies to facilitate implementation of the right to health.[48]

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[42] Ibid.
[43] Ibid., para. 42.
[44] Ibid.
[45] Ibid.
[46] Ibid., para. 64.
[47] Ibid.

### 4. The World Health Organisation

Throughout the General Comment on the Right to Health are numerous references to the work and influence of the WHO. In particular, the Committee on Economic, Social and Cultural Rights recognises "the key function assigned to WHO in realizing the right to health at the international, regional and country levels...".[49] It is clear, the Committee considers that a close working relationship with the WHO is a necessary component of monitoring and developing the right to health.

> "The realization of the right to health may be pursued by numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments."[50]

The General Comment on the Right to Health also entrusts the WHO, along with UNICEF, with the development of appropriate right to health indicators that reflect the various aspects of the right to health.[51] States parties are encouraged to utilise the "extensive information and advisory services of WHO as regards data collection, disaggregation, and the development of right to health indicators and benchmarks".[52] Along with other UN institutions, the WHO is expected to utilise its mandate to assist states to implement the right to health at the national level[53] and to ensure that the organisation takes due account of the right to health.[54] It would seem to be the assumption of the Committee on Economic, Social and Cultural Rights that much of the WHO's work is or could benefit the implementation of the right to health even when the policy was not specifically developed for that end. For example the Primary Health Care approach adopted by the WHO as part of its Health-for-All programme has clearly been influential in the development of the core content of the right to health as set out in the General Comment on the Right to Health.[55]

## B. Evaluation of the General Comment on the Right to Health

The General Comment on the Right to Health will have a major impact on international understanding of the right. At this stage authoritative direction was essential if the right was to gain the international respect it deserves. It is an expansive document that seeks to establish health as a subject of fundamental social

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[48] Ibid.
[49] Ibid., para. 63.
[50] Ibid., para. 1.
[51] Ibid., para. 57.
[52] Ibid., para. 63.
[53] Ibid., para. 64.
[54] Ibid., para. 39.

and political concern. The Committee on Economic, Social and Cultural Rights does so by providing a liberal definition of Article 12 of the ICESCR and ensuring that the term right to health is considered in the broadest context, even beyond the scope of the ICESCR itself.

The General Comment on the Right to Health recognises health as being essential to the enjoyment of other human rights thereby emphasising its importance to society.[56] The rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement as well as other rights and freedoms are acknowledged as being integral components of the right to health.[57] Acknowledging the impact of health on a wide range of rights also highlights the significant inter-relationship of rights and the need to consider human rights in their entirety.

The Committee on Economic, Social and Cultural Rights is the second formal body to clearly outline the normative content of the right to health but it has sought to place the right to health in its broadest context.[58] It has adopted a holistic approach to health that includes the right to health care but also recognises a wide range of socio-economic factors that affect an individual's ability to lead a healthy life as well as underlying determinants of health.

It is clear that the primary focus of the General Comment on the Right to Health is on the legal obligations that State parties have in relation to the right to health. It uses the tripartite approach to more comprehensively detail the acts and omissions that are encompassed in the right to health. By so doing, the Committee on Economic, Social and Cultural Rights provides a blueprint to direct the appropriate aims and objectives of health policy at the national level. A violations approach is also utilised to reiterate the principle obligations and by adopting such strong language, the Committee focuses its powers of enforcement on the fundamental aspects of the right. At the same time, the Committee on Economic, Social and Cultural Rights clearly wants to establish a positive dialogue with the State parties to formulate

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[55] See chapter 4 for details on primary health care and Health-for-All.
[56] General Comment No.14, para. 1.
[57] Ibid., para. 3.
[58] The General Recommendation on Women and Health adopted by the Committee on the Elimination of All Forms of Discrimination Against Women was the first formal conceptualisation of the right to health but it was more limited in scope. Refer to chapter 2 for details.

appropriate standards in the form of benchmarks. Cumulatively, the Committee on Economic, Social and Cultural Rights has developed a comprehensive approach to enforce the right to health that differentiates the essential elements of the right to health from the more aspirational.

The most important function of the General Comment on the Right to Health has been to break through the various theories and interpretations concerning the right. It is now incontrovertible that the right to health is an important legal concept that gives rise to legal obligations, rights, freedoms and entitlements. Even though it is a very detailed and specific commentary, no single document can provide all the answers, but it has provided the essential framework from which the right to health can develop.

### C. Limitations of the General Comment on the Right to Health

The General Comment on the Right to Health is an essential beginning but not an end. Because of it, significant advances have been made in the conceptualisation of the right to health but further work is needed. Four areas require particular note. Some integral definitions and concepts remain vague, the globalisation of health needs to be addressed in detail, the responsibilities of non-state actors needs to be developed further, and normative standards need to be developed to detail specific obligations in relation to the right to health.

#### 1. Clarification of definitions and concepts

As has already been stated, the Committee on Economic, Social and Cultural Rights should be praised for recognising that health is a notion that is historically contingent. Since the drafting and adoption of the ICESCR in 1966, there have been substantial changes to the world health situation that have led to a shifting perception of health. the Committee on Economic, Social and Cultural Rights, therefore, has adopted a holistic approach to health that looks beyond the prevention and curing of disease to consider the broader socio-economic factors and underlying determinants of health. However, the scope of the factors to be considered remains vague.

The Committee on Economic, Social and Cultural Rights provided examples of socio-economic factors and underlying determinants of health that range from tobacco and drug usage to violence and armed conflict including the use of nuclear weapons. However, since these are only examples, does this mean that

there is an obligation on State parties to deal with any factor that could impact on health? If so, is this a problem? Some may consider that a definition of the right to health that encompasses all factors that impact on health would be too broad to be effective but I would disagree. Society is becoming more aware that a wide range of actions has health implications and that choices or compromises have to be reached. Society needs to be more aware of the choices it is making and the detrimental effect on health that may occur as a result.

No model is provided in the General Comment on the Right to Health as to how the process of assessing the implications of policy on health should occur. In many states, before decisions are made that impact on the environment, environmental impact assessments are routinely performed. Health impact assessment models could be developed to the same ends. The Committee on Economic, Social and Cultural Rights does not have the expertise to develop such a model but the use of such a model could lead to the establishment of a hierarchy of rights or compromises that could impact on the human rights system and so the Committee would have an important monitoring role in this regard.

The Committee on Economic, Social and Cultural Rights has recognised the inter-relationship of rights and has stressed the indivisibility of rights, but what factors need to be considered when the hard choices are to be made and competing rights need to be balanced. One important tool advocated by the Committee on Economic, Social and Cultural Rights is the need for public participation in all health-related decision-making. While public participation is to occur at the community, national and international levels according to the General Comment on the Right to Health, no system is set out to facilitate this process. The Committee on Economic, Social and Cultural Rights can monitor the attempts made to adopt such a process to ensure that fair and equal access is assured but is not in a position to help States fulfil their obligations by advocating the process to be adopted. Again, it does not have the expertise in this field and as yet no successful model has been developed.

The Oregon Health Plan represents one approach to attaining supportable public policy. According to Sipes-Metzler, there were four essential elements to the plan:

- Oregon developed a process for citizen participation in policy debate;
- Oregon changed the question to be debated from who should be covered to what is covered;

- Oregon created a process to allow the legislative focus to be on tradeoffs in the areas of least effectiveness; and
- The state interfaced with the public, experts and the legislature in a content neutral manner in the blending of medical fact and public values to form public policy.[59]

Even though the Oregon Health Plan has had problems, and can be criticised, it does serve as an example of the practical possibilities of public participation.[60] Other options include empowerment via a social charter or a code of patient rights, but as yet such options have not been evaluated or advocated by the Committee on Economic, Social and Cultural Rights.

**2. Globalisation of health**

The rapid shift towards globalisation coupled with the movement to improve co-operation in health has lead to the development of such notions as globalisation of health and global governance in health.

> "Globalisation is defined as the process of increasing economic, political and social interdependence and global integration that takes place as capital, traded goods, persons, concepts, images, ideas and values diffuse across state boundaries."[61]

The new phenomenon of globalisation necessarily impacts on the health status of both developing and industrial states' populations, as well as the sustainability and development of health care systems in general. In some instances the impact could be positive, e.g. if new technology were to be made available to developing countries. However, it is more likely to have negative results.[62] There is no system established yet to assess the potential impact of global policy on health, never mind to ensure that such assessments receive due consideration. The Committee on Economic, Social and Cultural Rights has highlighted some of the obligations on states in relation to privatisation but is limited by only being able to address states. The monitoring and regulation of the impact of global policy on health could only be conducted by an international organisation, such as the WHO, with a broader health mandate.

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[59] Sipes-Metzler, P. (1994): 'Oregon health plan: ration or reason.' Vol.19 The journal of medicine and philosophy, pp.305-313, p.313.
[60] And it does offer a blueprint that could be modified to enable consideration of global health issues.
[61] Yach, D. & Bettcher, D. (1998): 'The globalization of public health, I: threats and opportunities.' Vol. 88 American journal of public health, pp. 735-737, p.735.
[62] Ibid.

### 3. Non-state actors

While the predominant focus of the General Comment on the Right to Health was to identify legal obligations on State parties, the Committee on Economic, Social and Cultural Rights did acknowledge that non-state actors also had 'responsibilities' in relation to the right to health. Little clarification was provided as to the level of responsibility or means of enforcement of these responsibilities. Could these responsibilities be developed to become legal obligations? Clearly, this is beyond the scope of the ICESCR because ratification of it can only give rise to legal obligations on states. Nevertheless, there should be obligations on non-state actors.

i) *Individuals*

Adopting the approach that individuals have responsibilities in relation to the right to health is a dangerous route to take and could have a detrimental effect on the notion of the right to health and its future development. By so doing, the actions and behaviour of the individual becomes the primary focus of attention and this distracts from the responsibilities and obligations on other actors whose actions have a sustained impact on the right to health of large population groups.

There has already been a proposal for the UN General Assembly to adopt a 'Universal Declaration on Human Responsibilities,'[63] but such an approach would only have clouded the principles of human rights and make their clarification more difficult. However, a 'Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to promote and protect universally recognized human rights and fundamental freedoms' was adopted by the UN General Assembly in March 1999.[64] This document mainly

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Particularly see table 1—'Health and Global Change' that analyses various global transnational factors and the consequences and probable impact on health status e.g. structural adjustment policies and downsizing could lead to marginalisation, poverty, and an inadequate decrease in social safety nets.

[63] On 1st Sept. 1997, the text of a draft Universal Declaration of Human Responsibilities was launched by the InterAction Council, a group of former government leaders, acting in their personal capacities, with Helmut Schmidt, former German Chancellor, as Honorary Chairperson and Malcolm Fraser, former Prime Minister of Australia, as Chairperson. Composed of 19 articles, the draft declaration tries to elaborate "norms of good behaviour, including honest dealing, speaking and acting truthfully, commends non-violence and generally showing respect to others".
For further details see Amnesty International Report (1998): 'Muddying the waters. The draft 'Universal Declaration of Human Responsibilities': No complement to human rights. IOR 40/02/98 [http://www.amnesty.org/ailib/aipub/1998/IOR/I4000298.htm]

[64] UN General Assembly Resolution, A/RES/53/144 adopted on 9 December 1998. With a follow-up resolution by the UN General Assembly, 25 February 2000 (A/RES/54/170) concerned to give effect to the 'Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to promote and protect universally recognized human rights and fundamental freedoms.'

concerns the ability of the individual to utilise her/his human rights, but there is also broad reference to individual responsibilities. Article 16 emphasises the important role that "individuals, non-governmental organizations and relevant institutions" have in relation to increasing public awareness with regard to all human rights, Article 18 concerns the duties and responsibilities of the individual to respect human rights and the freedom of others.[65]

It is easy to see how emphasising individual responsibility may be appealing, particularly when considering the concept of a right to health. There is currently no international consensus as to the nature of this individual duty to health. The only exception is when an individual's action may pose a threat to public health, e.g. by refusing to allow a vaccination.[66] As far as Churchill is concerned, the responsibility of individuals must be grounded in their awareness that health resources will always be scarce relative to need.[67] However, this is counter-balanced by advocating that such a health-related civic responsibility for prudent use and equitable burden of cost will only arise once the right of access to adequate health care for all has been established in practice.[68]

Those who support the 'Good Behaviour' model of health would argue that each individual has far greater responsibilities. The logic being that as health is a human construct, it is within human control and therefore the individual's responsibility. By making certain lifestyle choices, the individual can seriously impact on her or his health, leading to sickness. As each person is the first agent of her or his own health, it has been argued that the right to health services should be forfeited or weakened when a person chooses to

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[65] Article 18:
1. Everyone has duties towards and within the community, in which alone the free and full development of his or her personality is possible.

2. Individuals, groups, institutions and non-governmental organizations have an important role to play and a responsibility in safeguarding democracy, promoting human rights and fundamental freedoms and contributing to the promotion and advancement of democratic societies, institutions and processes.

3. Individuals, groups, institutions and non-governmental organizations also have an important role and a responsibility in contributing, as appropriate, to the promotion of the right of everyone to a social and international order in which the rights and freedoms set forth in the Universal Declaration of Human Rights and other human rights instruments can be fully realized.

[66] Fuenzalida-Puelma, L. and Connor, S. (eds.) (1989): Right to health in the Americas: a comparative constitutional study, p.600.

[67] Churchill, A. (1994) ): 'Aligning rights and responsibilities' in Chapman, A. (ed.) Health care reform: a human rights approach., pp.142-147.

[68] Ibid., p.143.

damage her or his own health.[69] This suggests there could be an obligation on an individual to be in good health and to act in the best interest of her or his own health. However, I agree with Montgomery when he said:

> "Good health cannot (and should not) be forced upon citizens. Any system of health rights must protect individuals against being forced to conform in a way which may unnecessarily compromise their freedom."[70]

This recognition that health is largely a product of human construction is important for the development of the right to health, but such benefits will be short lived if this leads to the assumption that health, or more precisely ill-health, is simply a matter of individual construction. Such a position fails to recognise the underlying economic and social factors that influence the individual's decision and the resulting impact that this decision can have on the individual's health status.[71] The right to health can support and facilitate a self-care approach to health, but good health should not be forced.

> "[For] each person is the first agent of his own health; this is true when a certain level of development is reached, since in destitution the destitute is no longer in control. It is only beyond destitution that one perceives this individual responsibility which exists without doubt; development only gives men back their individual responsibility, and collective action is meant so that finally man alone can exercise the last option..."[72]

At present the only possible obligations on the individual with respect to the right to health should be to respect the rights of others and to refrain from acts that would negatively impact on the health of others.

Conversely, the acknowledgement that individuals also have legal entitlements in relation to the right to health is significant but can have limited effect as long as the system of complaint, protection and enforcement within a democratic legal and political system at national level are restrictive.[73] At the international level, currently, there are equally limited complaint mechanisms available.

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[69] Ibid.
[70] Montgomery, J. (1992): 'Rights to health and health care' in Coote, A. (ed.) The Welfare of citizens. Developing new social rights, p.86.
[71] Such a position also exaggerates the available level of knowledge with regard to causes of ill-health, it places blame on the victim, the poor and the exploited and is punitive to the sick.
[72] Dupuy, R. (1979): The right to health as a human right, p.482.
[73] Generally, to utilise the court system for issues of public law an individual is required first to prove sufficient *locus standi*, which seriously restricts access. Court action is thus limited to criminal actions, gross negligence or personal tort actions.

ii) *Communities*

A local community is not the same as the state, although it may be strongly directed and influenced by the state. It is a coalescing of separate individuals who live in the same locality and therefore have similar needs while retaining their intrinsic identities and individual rights. Such a community is rarely recognised as having rights, but in reality many social rights can only exist by individuals forming such an external community relationship. [74] I believe that there is certainly a need for community as well as individual rights.[75] Affirmation and protection of individual and community rights could be achieved by:[76]

1) Group action on behalf of individual members. In this way, health-based interest groups could raise complaints on behalf of those that they represent. In so doing they protect interests where individual enforcement would be ineffective.[77]

2) The establishment of intermediate agencies to monitor and enforce standards at state level. Such agencies would have the ability to challenge powerful, vested interests and have the ability to investigate and enforce beyond the reach of the individual on issues such as pollution, health and safety etc.

3) The establishment of local, regional and international agencies to improve the health education of individuals and communities and provide information to enable the individual and community to attain maximal health status.[78]

4) The establishment of an international agency to oversee and facilitate state and community action on health, monitor standards to ensure attainment of a 'minimal' standard, mediate agreement on a community health charter, and establish dialogue at all levels to ensure appropriate standards exist at the international level.[79]

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[74] The external element of a right to health such as the right to fresh drinking water, hygienic sanitation, a clean environment, appropriate education, to participation in decision making process and an effective grievance procedure, cannot be attained or maintained in isolation.

[75] At present there are simply:
i) individual rights, which are considered to be human rights; and
ii) collective rights, which are rights *sui generis* (i.e. not human rights).

[76] The first two suggestions are based on the work of Montgomery (1992), pp. 89-90.

[77] The group complaint procedure under Article 2 of the 1995 Additional Protocol to the European Social Charter (not yet in force) already recognises the right of representative national non-governmental organisations to lodge complaints

[78] This builds on the existing work and structure of the WHO. See chapters 4 and 6 respectively.

[79] This is based on my concept of a permanent Academy of Health to be discussed in detail in chapter 8.

Such approaches are essential for the right to health to have a legal effect at the grassroots level. Social status, economic resources and political discretionary power can prevent the individual from promoting her or his right. But as a member of a community, with a desire to protect a corresponding community right, the balance of power is tilted more favourably. In this way, the potential to ensure the right to health is enhanced. Therefore, the notion of community rights should be developed along side the clarification of community responsibilities.

iii) *Non-governmental organisations*

NGOs may be the only mechanism through which the community can voice its concerns and protect its rights. They act as the conduit to put forward alternative positions and lobby for consideration. Currently, grassroots NGOs are one of the few ways that alternative voices can be heard. They can also monitor and protect rights in the localities thereby providing a limited measure of accountability for international agencies, state policy and other organisations. Unfortunately, resources and an inability to gain legitimacy often limit the impact of local NGOs. Monitoring and protection of the right to health would be greatly enhanced if a system could be established to promote the dialogue between the grassroots, NGOs, states and international organisations.

Conversely, international NGOs are often the primary source of aid in a region and as such can have a significant impact on the society it is seeking to help. Despite altruistic motives the results can, on occasions, still be negative, detrimental or have unforeseen side effects. For example, the agenda of the local population can be usurped by the injection of capital by an international NGO to achieve a specifically designated goal. The responsibility to monitor the work of aid agencies lies with the domestic government but this monitoring can be difficult to achieve if the need for assistance is great or the power of the government weak. As a result, the accountability of aid agencies is limited and their power and influence can be great. Reliance on the morality and acumen of the agency's board of governors is insufficient protection for the right to health. Legal obligations for international NGOs and an effective monitoring system need to be developed to ensure that the right to health is properly promoted.

iv) *Multinational organisations*

There is growing recognition that some large multinational corporations are more powerful and have greater resources than some smaller states. As a result, the decisions that they make or action they take can have a profound impact on the right to health yet their level of legal accountability is limited. The General Comment on the Right to Health places the responsibility with the state to monitor the action of third parties. The practicalities of doing so in the case of multinational organisations, however, may be limited by for example: inadequate resources, intellectual property considerations or free trade agreements. Organisations that are driven by profit are unlikely to respond to moral or political pressure alone although the recent case concerning the 39 pharmaceutical companies and South Africa has shown that this approach can be effective.[80] The concept of the responsibilities of multinational organisations needs to be developed so that such organisations are forced to consider the health implications of their policies and account for their actions.

v) *International organisations*

A more recent realisation that many factors that impact on health have no respect for state boundaries has prompted a gradual shift in approach to consider broader issues of responsibility for health. The rapid development of globalisation and recognition of the need for global governance in health raised the profile of obligations and duties of international organisations. The Committee on Economic, Social and Cultural Rights advocates that the UN specialised agencies adopt a human rights-based approach in order to facilitate the implementation of these rights. The enforcement of these obligations remains unclear, but the Committee is generally seeking to actively encourage greater co-ordination and communication with a strong underlying emphasis on human rights principles impacting the decision-making process within the

[80] In the court case between 39 Pharmaceutical firms and the South African Government concerning`` compulsory licensing and parallel imports of medicines in South Africa, the case was dropped by the pharmaceutical companies following intense media coverage and public demonstrations in numerous countries.
[Treatment Action Campaign, (2001): South Africa and access to pharmaceutical drugs: friends of the court: questions and answers. http://www.tac.org.za/ns010313.txt, p.1 downloaded June 2001.]
Similarly, the United States brought a complaint against Brazil at the WTO that Brazil's "local working" requirement in its patent law, seeking to protect its national drug programmes and free treatment programme for people with HIV/AIDS, was in violation of the Agreement on Trade. This was similarly dropped following intense medial coverage and public demonstrations.
[Treatment Action Campaign, (2001): TAC Statement on US Complaint Against Brazil at WTO. http://www.tac.org.za/usvsbrzl.html, downloaded June 2001.]

international arena.[81] These specialised agencies must have responsibilities in relation to the right to health and there is a need to establish legal obligations that will better protect and promote the right.

## 4. Normative standards

The General Comment on the Right to Health established legal obligations on states to collect data; ensure that statistical information was disaggregated in accordance with right to health principles; and develop indicators and benchmarks that effectively monitor the right to health without providing the normative standards that should be used to analyse this information. Similarly, a model has to be developed and agreed upon by which policy can be assessed and its potential impact on the right to health considered prior to adoption. Unless such tools are created, it is difficult to see how the Committee on Economic, Social and Cultural Rights is going to protect and monitor the right to health. Equally important for the protection of the right to health is the need to establish norms and principles that will enable individuals, including health professionals, families, local communities, intergovernmental and non-governmental organisations, multinational corporations and international agencies to address new developments that will impact on the right to health.

### i) *Indicators, benchmarks and health models*

The Committee on Economic, Social and Cultural Rights is dependent on other organisations such as the WHO to develop health indicators and benchmarks. The Committee is equally dependent on external bodies to collect and analyse the resulting data unless it is prepared to accept the statistics of the state that it is seeking to assess. The development of right to health indicators and benchmarks are an important step in the enforcement of the right. But the indicators and benchmarks that are used will also have a profound effect on the perception of the right to health itself. Therefore, it is extremely important that the health indicators and benchmarks adopted reflect the current understanding of the right to health and the direction in which society wishes the concept to develop. An organisation such as the WHO has its own particular understanding of the right to health and consciously or unconsciously is likely to develop indicators and benchmarks that reflect this corporate position. To ensure a more rounded model is developed, there needs to be a greater level of collaboration between human rights experts and health professionals than currently

[81] The suggestion seems to be that the Committee will use individual state reports to indirectly assess the effect of the policy of international institutions and its conformity with human rights obligations.

exists. This is true not only for the development of indicators and benchmarks but also for a health impact assessment model.

One potential indicator arises from the duty on the state to maintain at least a minimum level of health care.[82]However, the failure to require a government to allocate a specific amount of its budget to health still gives the impression that the amount a nation can afford to spend on the pursuit of health is what it chooses to spend.[83] (As the United States has shown, however, large scale spending on health care alone does not ensure an effective system for all.) The World Bank has developed the DALY (disability adjusted life year) as a neutral tool to assist in quantifying the economic burden of providing health care. By combining losses due to morbidity and premature mortality into a single indicator, more accurate comparisons can be made of the relative disease burdens due to different causes or groups of causes and of disease burdens in different populations.[84]

Concern has been expressed about using a purely economic analysis of disease and the social burden of disease by placing a monetary value on everything.[85] However, DALY is a useful tool to assist in the realities of rationing and the inevitable decisions that society has to make. Of course, it is impossible to programme in the personal element of ill health, but it may prove useful in monitoring the effectiveness of health care systems relative to expenditure and informing public debate. Is the adoption of such an approach likely to have a positive or negative impact on the right to health? The Committee on Economic, Social and Cultural Rights alone is not in a position to judge and therefore needs to establish a working relationship with health professionals.

ii) *Right to scientific progress*

Developments in the field of biotechnology are often debated in isolation from the right to health, as it is a new and rapidly developing speciality, but such scientific advances raise significant practical as well as

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[82] According to the Committee on Economic, Social and Cultural Rights in its recent General Comment on the Right to Health – see chapter 3 for details and Annex II for text.
[83] Tomasevski, K. (1995a): 'Health rights' in Eide, A., Krause, C. and Rosas, A. (eds.) Economic, Social and Cultural Rights: a textbook, pp.125-142, p.133.
[84] Morrow, R. & Bryant, J. (1994): 'Measuring and valuing human life: cost-effectiveness, equity and other ethics-based issues' in Bankowski, Z & Bryant, J. (eds.) Poverty, vulnerability and the value of human life: a global agenda for bioethics, p.53.
[85] See the remarks of Benatar in the article by Morrow and Bryant (1994), p.55.

ethical considerations. Growth in this field must impact on an individual's entitlement to health. A person's right to the benefits of scientific progress requires equal consideration and equal access to appropriate new treatment. Current property rights and procedural costs, however, risk limiting the availability of such breakthroughs to the economically advantaged. Such a right has to be balanced against the right to liberty and security of person, as ownership of the right to familial and ethnic autonomy may be disputed. New issues of confidentiality and consent also need to be determined. These developments should be considered in relation to the right to health but they are not considered in the General Comment on the Right to Health. Much will depend on whether, in the next few years, the human rights system develops to provide a conduit for public debate and actively seeks to promote individuals' abilities to protect their own right to health.

**D. Conclusions**

The adoption of the General Comment on the Right to Health by the Committee on Economic, Social and Cultural Rights was critical for the development of the right to health. Now there are substantive legal obligations emanating from the right to health and the fundamental role of health in society has been recognised. A human rights framework to monitor and enforce the right to health has been established. All these are exciting and significant milestones for the right to health but they are only the beginning because while the General Comment on the Right to Health has gone a long way to conceptualising the right to health it has limitations. The further development of the right to health, however, is not only beyond the mandate of the Committee on Economic, Social and Cultural Rights but beyond its resources and technical expertise. The General Comment on the Right to Health has established a clear framework for the right but without further interaction between human rights experts and health professionals it is difficult to envisage the further development of the right to health so as to ensure it has the broadest practical impact. The Committee on Economic, Social and Cultural Rights has already recognised the special position that the WHO should have in relation to the right to health. The WHO, as the specialised agency of the United Nations concerned with health, would seem to be the obvious agency to facilitate this collaboration between the human rights treaty bodies and health professionals so as to harness the current momentum that has resulted from the dialogue prior to the adoption of the General Comment on the Right to Health. There is a unique opportunity for the right to health and the WHO to move forward together providing the organisation has the mandate, structure and will to adopt the right to health.

## 4.
## The World Health Organisation and its Health-for-All policy

The WHO was established in 1948 as a specialised agency of the United Nations on the premise that health is essential to international peace and security. It has had a number of significant achievements over the last 50 years including the eradication of smallpox, improvement in polio control, development of simple and effective management of diarrhoeal diseases, development of the Codex Alimintarius, and instigation of the International Code of Marketing of Breast-Milk Substitutes. The Alma-Ata Declaration, introducing the Health-for-All programme, and its subsequent implementation has been the main focus of WHO since 1978 and has been very influential in the field of international health as well as being reflected in the General Comment on the Right to Health adopted by the Committee on Economic, Social and Cultural Rights.[1] This chapter will, therefore, examine the mandate of the WHO as established by its Constitution before considering how this has been interpreted through its policy. The chapter will focus attention on the Health-for-All programme and the subsequent revision of this strategy to establish the connection to the right to health. With the final section of the chapter analysing the future policy options for the WHO.

### A. Original mandate under the Constitution of the World Health Organisation

The Constitution of the WHO was shaped by the reactionism and idealism characteristic of the immediate post war period. This constitutional mandate is the foundation for the organisation. There was a high level of expectation and optimism among the delegates at the early plenary sessions.[2] Parron[3] considered that the nations represented were signing a 'Magna Carta for health,' while in the opinion of Bustos:

> "the adoption of the Constitution would signify that, in the future, health would be no longer a matter of private interest to the individual and to the State, but a matter of social interest and world-wide implications."[4]

Such rhetoric suggests that many of the delegates recognised that the development of a WHO was not only a momentous event but also heralded a new, broader and more inclusive approach to health. Initially, at least, there was a strong desire to reach beyond the limits of state sovereignty to affect individuals.

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[1] The Alma-Ata Declaration was the formal announcement of the Health-for-All programme in 1978 [reproduced in Alfredsson, G. and Tomasevski, K. (eds.) (1995): A thematic guide to documents on the human rights of women, pp.19-24].

[2] The delegates were predominantly from the field of public health rather than legal experts.

[3] Parron, T. (1946): 'Chapter for world health', Vol. 61 Public health reports, pp.1265-1268, p.1265.

## 1.The Preamble

Particularly noteworthy was the recognition, in the preamble, of the principle that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Since the Constitution of the WHO predated the 1948 Universal Declaration on Human Rights, this was the first formal statement of health as a human right. An idealistic standard for health was established to ensure that the WHO's mandate would not become outmoded. Throughout the preamble there is a strong emphasis on equality at all levels. This emphasis also includes equality among states as the preamble warns of the danger of unequal development, thereby reflecting the development of obligations on the international community towards the right to health. Public participation is also strongly advocated and is considered in terms of access to information, debate and openness. Implicit is the notion of democracy, open decision-making, goal setting and standard building that involves the international community, states and individuals. This clearly provides a strong human rights ethos on which to build. The preamble has a much stronger orientation to human rights concepts and philosophy than is generally acknowledged. The focus is usually simply placed on the recognition of health as a human right. This recognition is important, but the rest of the preamble seeks to guide the WHO towards attainment of such a goal.

The other much-quoted part of the preamble is the portion that defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This revolutionary definition remains the primary definition of health even though it has also been the subject of much academic criticism.[5] Such a broad definition can still act as a boundary marker for the WHO even if it may be difficult to establish a clear demarcation based on either subjective or objective criteria.[6] It is interesting to also note that proposals currently being considered amend this definition to include spiritual well being and the dynamic nature of health.[7] Because the original definition of health provided by the

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[4] Proceedings and final acts of the International Health Conference, 1946,Official Records No.2, 11th plenary meeting, p. 67.
[5] See chapter 2 for further details.
[6] Should there be any dispute as to the legal ambit of the WHO, the ICJ is available to act as final arbiter.
[7] To be found in 'Review of the Constitution an regional arrangements of the World Health Organization', report of the special group, November 1997, Official Records EB101/7. Adopted by the EB in January 1998, [101st session, Official Records EB101.R2, 'Review of the Constitution of the World Health Organization. Report of the Executive Board special group] and presented to the WHA in document A52 24, April 1999, 'Amendment to the Constitution: Report by the Secretariat' but as yet no formal decision has been made.

preamble is so widely accepted, it will be interesting to see the international reaction should these amendments ever take effect.

What is the legal status of these 'principles' encapsulated merely in the preamble? According to the then Secretary, the "[p]reamble was not an integral part of the Constitution, but its introduction and explanation. It did not have the legal force of the articles of the Constitution."[8] However, according to the Vienna Convention on the Law of Treaties, 1969,[9] for the purpose of treaty interpretation, the context should comprise of the text including its preamble and annexes.[10] The European Court of Justice has placed great importance on the Treaty of Rome's preamble to aid in the interpretation of the 'ordinary meaning' of the text 'in the light of its object and purpose'.[11] Therefore these 'principles' should be considered an integral component of the Constitution. In fact, these ideals were the cornerstone of the envisaged international health organisation. There was a clear desire to establish an organisation concerned with global health at the international, state and individual levels strongly grounded in human rights ethics.

## 2. The stated objective of the World Health Organisation

Article 1 of the Constitution establishes a single over-arching objective for the WHO: "attainment by all peoples of the highest possible level of health." The International Health Conference, 1946, deemed it appropriate to have a single overall objective but the objective provided for the WHO is perhaps too idealistic and unattainable to be of use to decide policy or to provide a clear corporate direction.

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[8] Proceedings and final acts of the International Health Conference, 1946, Official Records No. 2, 8th plenary meeting, p.49.

[9] Which, according to Article 5 of the Vienna Convention on the Law of Treaties, does apply to treaties constituting international organisations.

[10] Article 31.2. of the Vienna Convention on the Law of Treaties.

[11] This is also the necessary criteria established by Article 31.1 of the Vienna Convention on the Law of Treaties, to enable the interpretation of treaties.
For examples of cases that illustrate the willingness of the European Court of Justice to use contextual and purposive interpretation see:
Case 28/66 *Netherlands v Commission* [1968] ECR 1, and

## 3. The defined functions of the World Health Organisation

The Constitution of the WHO tries to give substance to its definition of health and sole objective by providing 22 explicit functions. These can be consolidated into 6 separate categories:[12]

i) *General and co-ordinated tasks*

The WHO is given specialist competency within the United Nations in relation to international health so that the organisation is empowered 'to take all necessary action' to further its aims within its field of competence. This validates the WHO's efforts to establish itself as the leader in international health rather than restrict itself to becoming a technical health organisation.

ii) *Co-operation with other organisations*

The drafters recognised that active and sustained co-operation would be required with other international agencies such as ILO, FAO, UNESCO and human rights treaty monitoring bodies in order to achieve improvement in many of the economic and social aspects of health. Advocating co-operation and leadership in health was not considered by the drafting body to give rise to any conflict of interests. It is unfortunate that the WHO prefers to take a more isolationist approach despite its rhetoric to the contrary.

iii) *Research and technical services*

Research and technical services were envisaged to include a wide variety of activities with the broad aim of effective control and eventual eradication of disease. It was a conscious decision not to limit the range of possible work by identifying specific diseases. Similarly by not limiting research to medical research, it was also possible to include the "administration and social aspects of public health and medical care from the preventive as well as the curative standpoint, including hospital services and social security".[13]

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Case 75/63 *Hoekstra v Bedrijfsvereniging Detailhandel*, [1964] ECR 177.

[12] The language used at the beginning of Article 2 of the Constitution indicates that the functions listed are mandatory but not inclusive. Therefore, any extension would not require constitutional amendment as long as it was "necessary action to attain the objective of the Organization"(Article 2 (*v*)). The criteria that the WHO has subsequently used to determine if a particular matter can be taken up concern international feasibility and acceptability, universal nature of problem, possibility of assessing progress and results, and financial feasibility.
(See Proceedings and final acts of the International Health Conference, 1946, Official Records No. 2, Section III, summary report on proceedings, pp.17-18.)

[13] Article 2(*p*) of the Constitution.

iv) *Promotion and education activities*

Promotion and education activities include a specific mandate "to promote maternal health and child welfare and to foster activities in the field of mental health".[14] In conjunction with such agencies as ILO and FAO, the WHO will also institute action towards the prevention of accidental (chiefly household) injuries and "the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene."[15] Two kinds of educational work were considered appropriate areas of involvement for the WHO:

- "on the technical level, WHO will aid in bringing about improved standards of teaching and training in the health, medical, and related professions, including arrangements for the widest possible dissemination of scientific and technical knowledge both to research workers and to practitioners" [16] and
- the WHO will assist "in developing an informed public opinion among all peoples on matters of health" through its own publications as well as via the press, radio and film in close liaison with the public relations programmes of the United Nations and other appropriate agencies. [17]

v) *Field operations*

With the appropriate state consent, the WHO provides direct aid to improve national health services and appropriate technical assistance in emergencies, whether at the request of states or on its own initiative. Emphasis is placed on the fact that the WHO would not operate inside any country without consent.

vi) *Regulatory measures*

The WHO is authorised to adopt various binding and non-binding legal instruments to facilitate its objective. These include:

- formal recommendations,
- adoption of international conventions or formal agreements and
- issuing of regulations on specific subjects.[18]

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[14] Ibid., Article 2( *l* )
[15] Ibid., Article 2(*i* )
[16] Proceedings and final acts of the International Health Conference, 1946, Official Records No. 2, Section III, summary report on proceedings, p.17.
[17] Article 2 (*s*) of the Constitution.

It is important to note there is no suggestion to limit the WHO to medical issues only. On the contrary, the adoption of such a wide definition for health explicitly acknowledges the need for collaboration with all forms of organisations by envisioning a totally integrated system to include the United Nations, Member States, non-governmental organisations, professional bodies, regional groups and individuals. The other important function to highlight is the obligation to establish normative standards. The practical powers considered appropriate for the WHO to effect its objective are specified but the subject for such normative standards is less clear. Still, the list of functions provided can serve as useful indicators for the type of subjects deemed appropriate for the development of normative standards. It is certainly not limited to establishing and revising "international nomenclatures of diseases of causes of death and of public health practices"[19] but could be utilised to promote "prevention of accidental injuries" (Provision *h*); to promote "the improvement of nutrition, housing, sanitation, recreation, economic or working conditions, and other aspects of environmental hygiene" (Provision *i*); "to promote maternal and child health" (Provision *l*) etc. or more generally "international health matters".[20]

## B. Health-for-All and its connection to the right to health

Since its inception in 1978, 'Health-for-All' has become the principle focus of the WHO. This approach to health has received acclaim and has directed health policy at the international and state levels. For many, both within and outside the WHO, the Health-for-All concept has become synonymous with the right to health.[21] For this reason, it is necessary to consider the policy in detail to illustrate the organisation's current direction and to establish whether 'Health-for-All' is, in fact, synonymous with the right to health.

### 1. Pre Alma-Ata Declaration

While the original mandate of the WHO must be considered innovative, dynamic and exciting, the desire to avoid political controversy and to adopt a strong medical model negated this initial energy and led to the development of a predominantly conservative, technical ethos. That culture remains pervasive today and exerts undue influence within the organisation. It is useful to see how this developed.

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[18] The procedures and conditions necessary to exercise these functions are detailed in Chapter V of the Constitution. For a detailed analysis see Chapter 7.
[19] Article 2(s) of the Constitution.
[20] Provision 2(*k*) of the Constitution specifies such broad usage for the powers vested in the WHO.

One of the early successes in this disease-oriented approach to global health was the programme the WHO instigated to combat Yaws, a debilitating disease of skin, bone and joints. It afflicted 50 million people. As part of this initiative, the WHO defined its essential tasks as:

- international co-ordinator which would require the holding of international symposia;
- trainer which was to be fulfilled by offering fellowships to national staff; and
- disseminator, prescribing long-acting penicillin.[22]

Due to its success, this became the chosen format for many WHO programmes. "Recognizable as the 'Yaws' approach, today it consists of technical meetings, consultative visits, fellowship training, and the provision of supplies."[23] It proved to be an effective approach for the expanded programme on immunisation, in the eradication of smallpox and the potential eradication of polio. However, there have also been equally dramatic failures from this 'vertical' approach of targeting a single disease, most notably the WHO's attempt to eradicate malaria[24] and its initial response to the problem of HIV infection or AIDS. These failures illustrate that the 'Yaws' approach is limited to diseases where there is a simple technical solution. Unfortunately, in this complex and pluralistic society, there are few diseases or health issues that do not have a social or cultural component. Still, the WHO frequently prefers to adopt this technical-medical model despite the new approach hailed by the Alma-Ata Declaration.

## 2. The Alma-Ata Declaration

"Quite clearly what we tried to go for in Alma-Ata was to get out of the confusion that medicine is synonymous with health."[25] The Health-for-All strategy described in the Alma-Ata Declaration (Declaration) was hailed as a new orientation toward human rights, because in this Declaration the WHO

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[21] Although the phrase a 'right to health' is rarely used within WHO's official documents.
[22] Peabody, J. (1995): 'An organizational analysis of the World Health Organization: narrowing the gap between promise and performance'. Vol.40 No.6 Social science and medicine, pp.731-742, p.735.
[23] Ibid., p.736.
[24] The WHO has spent a great deal of time, energy and resources seeking to eradicate malaria with few results and as such has become the object of much criticism and controversy. For further details of this project see: Siddiqi, J. (1994): World health and world politics: a study of the World Health Organization.
[25] World Health Organization, (1988): From Alma-Ata to the year 2000: reflections of the midpoint, p.118.

sought to adopt a more holistic approach to health.[26] The recommendations put forward at the Alma-Ata Conference were certainly not new.[27] They were based on the provisions of Article 12 of the ICESCR and the human rights premise of social justice and equity, although no explicit reference was made to the right to health in the human rights treaties.[28] The aim of the Declaration was to restore the integrity of the WHO by creating a global mission statement on which to establish international leadership on health and to galvanise the international community into action.[29]

Health-for-All was to establish a practical health baseline below which no individual in any country should find himself. This baseline was to be set at a level of health that would allow each individual to work productively and to participate actively within their community.[30] The stated purpose of Health-for-All was:

> "to provide a conceptual framework for thinking about the multiplicity of problems, for guiding decisions about priorities and action with a special concern for equity in health, and for sharing experiences, problems and ideas with other nations in order to promote health and reduce health inequities."[31]

The Declaration has been said to have "provided the world with ethical precepts, political imperatives and technical directions that have since become critical guidance to the health and development community

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[26] And was hailed as such by Dr. Flach (Chairperson of the WHO working group on human rights) to the Committee of Economic, Social and Cultural Rights. See Report on the eighth and ninth session, UN ESCOR, Supp. 3, UN Doc. E/1994/23, E/C.12/1993/19, p.61.310.

[27] As noted by Navarro, V. [(1984): 'A critique of the ideological and political positions of the Willy Brandt report and the WHO Alma Ata declaration.' Social science and medicine, pp.467-474, p.471.] The Office of Health Economics, in 1972, and the World Bank, in 1975, both produced reports on the state of health and medicine in the underdeveloped world closely resembling the Alma-Ata recommendations.

[28] Grad, F. (1998): 'Public health law: its form, function, future and ethical parameters.' Vol.49, No.1 International digest of health legislation, pp.19-39, p.28.

[29] Curtis and Taket suggest that several factors combined to affect this shift in approach by the WHO away from the 'biomodel' to the 'socio-ecological' perspective. Such factors include: the role of non-medical health practitioners, development of feminist research into the impact of medical practice in constructing restrictive roles for women, the growth of alternative health and self-help movements within Western societies, and the use of paradigms from non-Western medical systems of thought.
See Curtis, S. and Taket, A. (1997): Health and society: changing perspectives, p.30.
The pervasive influence of human rights concepts and international attitudes towards development must also have made an impression because it was from these that the WHO developed the strategy of Health-for-All.

[30] Fluss, S. (1995): 'The development of national health legislation in Europe: the contribution of international organizations'. Vol.2 European journal of health law, pp. 193-237, p.208.

[31] As stated in World Health Organization, (1988): From Alma-Ata to the year 2000: reflections of the midpoint, p.76.

worldwide".[32] It sought to utilise a multisectoral approach that combined ethical, political, social and technical resources.[33]

Critics, however, have been frustrated by the interchangeable usage of the expressions 'health', 'healthcare', 'health care sector', 'medical care' and 'health systems'.[34] This led to the suggestion that underlying premise of the Declaration is simply to advocate a health care system built on and organised around the medical care system, i.e. health care goods and services provided to individuals and families by health professionals and health workers.

The Declaration itself was formulated at the International Conference on Primary Health Care, meeting in Alma-Ata on 12th September 1978.[35] The Conference reaffirmed the definition of health as established in the Constitution of the WHO and reiterated that health was a 'fundamental human right'.[36] According to section V, "[p]rimary health care is the key to attaining this target as part of development in the spirit of social justice". While the precise meaning of such a statement is unclear, it seems that the conference was keen to underline the inter-relationship of health to development and to place health in a broader social context.

The concept of primary health care, however, was given a great deal of attention:

Section VI

> Primary health care is **essential health care** based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination.
>
> It forms an integral part both of the country's health system, of which it is the central function and main focus and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing

[32] Ibid., p.62.
Mahler, at p.100, would go so far as to herald the Alma-Ata Declaration as a set of universal principles for health or " a social helix whose strands can shape many different systems in response to different needs and different capacities".
[33] Ibid., p.63.
[34] Navarro (1984), p.472.
[35] The phrase Health-for-All (by the year 2000) was coined at a later date by Dr. Mahler.
[36] Again, this may simply have been a reiteration of the wording used in the Constitution of the WHO. See section I of the Declaration of Alma-Ata reproduced in World Health Organization (1988), p.7.

> health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.[37]

Such a definition seems to be strongly influenced by the traditional medical model of health with the primary focus remaining on access to preventive medicine and medical services. This is not to deny the importance of such access particularly to individuals in the rural areas of less developed countries, but it is not a revolutionary or a multifaceted approach to health. However, in 1978, the notion of public participation[38] as an essential tool for health was novel, particularly when the responsibility for health was clearly established to be with the state.[39] It is not surprising that this element of primary health care has since been neglected by states.

In outlining the practical implementation of primary health care, a broader developmental approach to health was advocated in the Declaration. This included recognition that the promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation (Section VII.3) as well as agricultural methods, education, industry, food, housing, public works and communications (Section VII.4), can impact on health. Much of this list, however, had already been considered under the auspices of public health.

More innovative were the requests for inter-state co-operation:

> "in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country" (section IX)

and the request for international co-operation "in keeping with a New International Economic Order".

This outline for Health-for-All, as it became know, has since been expanded by WHA resolutions and re-affirmed at various international conferences. Although it was initially publicised as Health-for-All by the

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[37] Emphasis added.

[38] "The people have the **right** and **duty** to participate individually and collectively in the planning and implementation of their health care." (emphasis added) Section IV. [World Health Organization (1988)] This is the only time the notion of rights and duties is used within the text of the Declaration. It is difficult to surmise whether such rights and obligations are intended to be moral, legal or social and why such language is used only in relation to individuals and not in relation to respective governments who have only 'a responsibility' or the international community.

[39] Section V of the Declaration of Alma-Ata:
"Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures."
World Health Organization (1988).

year 2000, it was not considered to have a single, finite target date but rather to be a process leading to the progressive improvement in the health of people. It has also been necessary for the WHO to re-evaluate and re-direct the approach of Health-for-All based on state experiences and to accommodate changing circumstances. Implementation was initially to be based on personalised national strategies with regional strategies based on the national strategies so as to accommodate the special problems of the region concerned. The global strategy was to be the synthesis of the six regional strategies.[40] Time constraints, bureaucratic difficulties, and the reluctance of states to develop such strategies has meant that in reality the approach has been pre-dominantly instigated centrally from the WHO's Headquarters.[41]

***The essential elements of Health-for-All***

It is difficult to give a clear definition of primary health care even though it is considered the cornerstone of the Health-for-All approach.[42] Part of the problem is that the WHO adopted an 'à la carte' policy approach in which states were encouraged to select and emphasise particular elements of primary health care *they* considered appropriate to *their* needs. There were numerous components but some should have been considered essential elements. Yet, no fundamental minimum was established. Hence, the spectrums of components that in effect comprise primary health care are broad and varied.

For example, the WHO Regional Office for Europe attempted to set out the most crucial components. It considered that health promotion, prevention of ill health, and an accessible source of treatment when ill were the essential components of primary health care but with the emphasis on the first two components.[43] Health care was to be relevant, utilising appropriate technology with a focus on the predominant needs of the local community. The emphasis was on accessible, affordable and acceptable health care. The strategic organisation of health care had to be dynamic and sensitive to changing geographical, cultural and economic requirements. Such an approach could involve the incorporation of traditional local medical

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[40] Curtis and Taket (1997), p.258.
[41] There has been some regional initiatives formulated, particularly within the European Regional Office.
[42] There are various alternative definitions. See:
Tarimo, E. & Webster, E. (1997): Primary health care concepts and challenges in a changing world: Alma-Ata revisted, p.3;
Lawson, E. (1991): Encyclopaedia of human rights, p.705;
and Curtis and Taket (1997), p. 257; for alternative definitions of the essential components of primary health care.
[43] WHO Regional Office for Europe, (1982): Primary healthcare - from theory to action. Report on a WHO symposium.

practices and practitioners as Health-for-All sought to shift the focus of health care away from tertiary medicine. Emphasis on health prevention and health promotion strategies became based around education. Particular attention was advocated for vulnerable, minority groups that tended to have a poor health record. Responsibility for establishing and co-ordinating such a rounded economic, social and health policy programme was vested with the Minister for Health of the particular state.

According to an official report endorsed by the Executive Board of the WHO in January 1994, however, there are eight essential elements of primary health care:

- education concerning prevailing health problems and the methods of preventing and controlling them;
- promotion of food supply and proper nutrition;
- an adequate supply of safe water and basic sanitation;
- maternal and child health care including family planning;
- immunisation against the major infectious diseases;[44]
- prevention and control of locally endemic diseases;
- appropriate treatment of common diseases and injuries; and
- provision of essential drugs.[45]

Such an approach seeks to identify health with other social, economic and development concerns.

Despite the reiteration of health as a human right, there is little within the Declaration that specifically uses the language and concepts of human rights except in the area of individual and community participation where reference is constantly made to the "right and duty to participate". Within the framework of Health-for-All policy, the rights of the individual and community are limited to an entitlement to participate in the development of local health policy. There is no discussion as to how an individual or community can enforce or protect such a right. The rationale for community participation stems from several principles:

- People have a right to participate as citizens in development and nation building.
- When people participate, their economic productivity and implementation of programmes and projects are enhanced through high morale, better understanding and control over what is happening.

[44] These are diphtheria, tetanus, whooping cough, measles, polio, and TB.

- Sustainability is reinforced through community participation even after the external proponents or partners have left the community. [46]

The language frequently used suggests that participation should be considered as much an obligation as a right. Emphasis is placed on the benefits of personal responsibility as it enables personal growth so individuals consider themselves less the victim of disease or recipient of care but more a decision-making participant in their own health.[47] This leads to self-reliance by motivating individuals to resolve their own problems through improvisation and innovation.[48] As a result, "people can be important social carriers of their own health destiny".[49] The WHO recognised that such a position could not be attained without access to valid, objective information;[50] decentralised reform of state structures and a greater coherence of projects;[51] and development of institutional arrangements to provide mutual support, with feedback between government and community.[52] However, without the economic and social means of obtaining and maintaining living conditions and without the ability to enforcement their rights, individuals can simply feel demoralised rather than empowered.

In 1979, Walsh & Warren suggested a modification of the Health-for-All approach arguing that, services aimed at impacting on the most important diseases may be the most effective means of improving the health of the greatest number of people, until comprehensive primary health care could be made available to all.[53] This approach was advocated particularly for less-developed regions with high morbidity and mortality rates. Selective primary health care was considered to be the most cost-effective type of medical intervention. The principle recipients of care were to be children up to three years old and women in the childbearing years. The care provided was to be made up of measles and diptheria-pertussis-tetanus (DPT)

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[45] Executive Board, 95th session, November 1994, Official Reports EB95/15, 'Reviewing the Health-for-All strategy. Report by the Director-General.'
[46] According to the WHO, Regional Office for Africa in its report: The African response to the global philosophy of action for health, (1981), p.22.
[47] "By adopting a healthy life style, by applying principles of good nutrition and hygiene, or by making use of immunization services."
World Health Organization, (1978): Alma-Ata: primary health care, p.50.44.
[48] The African response to the global philosophy of action for health, (1981), p.34 and p.50.
[49] World Health Organization (1988), p.94.
[50] Ibid., p.94.
Such information needs to be presented in ways that make it semantically and culturally understandable.
[51] The African response to the global philosophy of action for health, (1981), p.15.
[52] World Health Organization, (1978), p.51.48.

vaccination for children over six months old, tetanus toxoid for all women of childbearing age, encouragement of long-term breast feeding, provision of chloroquine for episodes of fever in children under three years old and living in areas where malaria is prevalent, and oral rehydration packets and instruction.[54] Such an approach had appeal for remote areas where resources are more limited. But, it reverted to a medical model justified on the grounds of utilitarian principles: efficiency and effectiveness. This approach also suggested that, at its most basic, the Health-for-All approach remained predominantly medically orientated. Unfortunately, it had the effect of undermining the principles of primary health care. Although developed as an interim measure, it reiterated the selective approach to health that the Health-for-All programme advocated and justified states adopting only elements of the programme they considered appropriate.

In addition, the European Regional Committee of the WHO adopted 38 targets to "stimulate the public authorities, professional groups and the general public in every country to develop policies and programmes for health for all that are suited to their circumstances and needs".[55] This list, which is set out below, illustrates the essential components of Health-for-All and the direction this regional committee considered appropriate. It should, however, be remembered that these targets were compiled for a predominantly industrialised, prosperous region in which the majority of states already had a reasonably high standard of health.

**Health for All in Europe by the Year 2000[56]**

1 Equity in health
2 Adding life to years
3 Better opportunities for the disabled
4 Reducing disease and disability
5 Eliminating seven specific diseases
6 Life expectancy at birth
7 Reducing infant mortality rates
8 Reducing rates of maternal mortality

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[53] Walsh, J. & Warren, K. (1979): 'Selective primary health care. An interim strategy for disease control in developing countries.' Vol.301 New England journal of medicine, pp.967-974.
[54] Koivusalo, M. and Ollila, E. (1997): Making a healthy world. Agencies, actors & policies in international health, p.115.
[55] WHO Regional Office for Europe, (1991): Forty years of WHO in Europe, p.79.
[56] Ibid., pp.80-81.
It was expected that the last seven targets would be achieved first, since they supplied the necessary preparatory action to make possible the specific aims in the second group. This group established changes needed in lifestyles, the environment and appropriate health care. Only once these have been achieved can the targets 1-12 be met and these describe the changes required to achieve Health-for-All.

9 Combating diseases of the circulatory system
10 Combating Cancer
11 Reducing accidents
12 Stopping the increase in suicides

**Necessary Changes for Health for All**

**Lifestyles conducive to health**
13 Healthy public policy
14 Social support systems
15 Knowledge and motivation for healthy behaviour
16 Promoting positive health behaviour
17 Decreasing health-damaging behaviour

**Healthy environment**
18 Policies for a healthy environment
19 Monitoring, assessment and control of risks in the environment
20 Water pollution
21 Protection against air pollution
23 Protection from hazardous wastes
24 Healthy homes
25 Healthy working conditions

**Appropriate care**
26 A health care system based on primary health care
27 Rational and preferential distribution of resources according to need
28 Content of primary health care
29 Providers of primary health care
30 Coordination of community resources for primary health care
31 Ensuring the quality of services

**Research and Health Development Support**
32 Research and health for all
33 Policies for health for all
34 Management of planning and resource allocation
35 Health information systems
36 Planning, education and use of health personnel for health for all
37 Education of personnel in other sectors to support health for all
38 Health technology assessment

### *Health-for-All indicators*[57]

An important aim of the Health-for-All programme was to establish a system whereby health policy could be effectively monitored, evaluated and modified accordingly. It was recognised that this requires the collecting of consistent, objective and pertinent data. This could be possible through the development of a series of indicators. Unfortunately, while acknowledging that indicators had to be consistently introduced

[57] Indicators should not be confused with objectives and targets. Objectives are desired aims and targets are objectives that have been made more specific in quantified terms or in terms of time. "Indicators are used as markers of progress towards reaching objectives and targets."

at national, regional and global levels in order to permit further guidance to be possible, the programme encouraged states to adopt indicators based on the feasibility of gathering the information required because of the extensive range of possible indicators. Not only technical feasibility, but also the financial and managerial feasibility of collecting the necessary information was to be considered.

The WHO proposed adopting four categories of national indicators:

- health policy indicators;
- social and economic indicators;
- provision of health care indicators; and
- health status indicators, which includes quality of life.[58]

i) *Health policy indicators* include:

1) Political commitment to Health-for-All

– such an indicator is limited to declarations of high-level commitment, because qualitative indicators cannot be used to assess qualitative material.[59]

2) Resource allocation

– commitment to the Health-for-All strategy may require substantial reallocation of resources. This can be an important indicator of political commitment.[60]

3) The degree of equity of distribution of health resources

– examples include the distribution of per capita expenditure on health between geographical areas or between the capital city and the rest of the country; the proportion of total health resources going to primary health care by region or district; and the ratios of hospital beds, doctors and other health workers to population in different parts of the country.[61]

4) Community involvement in attaining Health-for-All

– including mechanisms and processes enabling people to become actively involved in health in partnership with health professionals.

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World Health Organization, (1981): Development of indicators for monitoring progress towards health for all by the year 2000, p.1.10.

[58] Ibid., preface.

[59] Ibid., Chapter 1.35

[60] Ibid., Chapter 1.37

[61] Ibid., Chapter 1.44

5) Organisational framework and managerial process

– one pertinent indicator, here, is the degree of decentralisation in terms of decision-making.[62]

ii) *Social and economic indicators* include

1) Rate of population increase is just one of the standard vital events rates along with birth and death rates.[63]

2) Gross national product or gross domestic product can serve as a general measure of human welfare even though there are some unfortunate anomalies in its formulation.[64]

3) Income distribution can be reflected indirectly by considering such indicators as occupational groupings or distribution of land, cattle and other possessions reflecting wealth.[65]

4) Working conditions.

5) Adult literacy rate particularly among women can impact strongly on health as women often act as primary health care providers in the home.[66]

6) Food availability

– food and personal nutritional status impact on health but at present, there is no single indicator that can take into account seasonal variations, differences between income groups or patterns of food distribution within households. The per capita energy availability is currently the best available indicator.[67]

iii) *Indicators for the provision of health care* include

1) Coverage of primary health care; and

2) Amount of coverage by the referral system.

Achieving meaningful indicators, however, is problematic. The only available option is to differentiate levels of the health care system, but the approach will vary depending on the system of health care established.

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[62] Ibid., Chapter 1.46
[63] Ibid., Chapter 1.53
[64] Ibid., Chapter 1.55
[65] Ibid., Chapter 1.59
[66] Ibid., Chapter 1.61
[67] Ibid., Chapter 1.65

iv) *Indicators of health status*

1) nutritional status and psychosocial development of children;

2) infant mortality rate

3) child mortality rate (ages 1-4 inclusive)

4) life expectancy at birth or at other specific ages; and

5) maternal mortality rate.

The work of the WHO in the area of indicators illustrates the problematic nature of the task. There is no such thing as a simple statistic. But the level of commitment to the process highlights its considered importance to the Health-for-All programme. It should be remembered that this broad range of available indicators was established for the use of states to assess, plan and evaluate its development of Health-for-All.

***Global indicators***

In addition to state indicators, the WHO's Health-for-All programme developed 12 global indicators to assess the international health situation. This list, however, was not a mandatory requirement and little political pressure has been applied to conform.[68] The following list of indicators was adopted by the Thirty-fourth WHA in 1981:[69]

> *The number of countries* in which:
>
> 1) *Health for all has received endorsement as policy at the highest official level*, e.g., in the form of a declaration of commitment by the head of state; allocation of adequate resources equitably distributed; a high degree of community involvement; and the establishment of a suitable organizational framework and managerial process for national health development.
> 2) *Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning*, i.e., active and effective mechanisms exist for people to express demands and needs; representatives of political parties and organized groups such as trade unions, women's organizations, farmers or other occupational groups are participating actively; and decision-making on health matters is adequately decentralized to the various administrative levels.
> 3) *At least 5% of the gross national product is spent on health.*
> 4) *A reasonable percentage of the national health expenditure is devoted to local health care*, i.e., first-level contact, including community health care, health centre care, dispensary care and the

[68] While it may seem logical to collect and evaluate health statistics, it is also a bureaucratic and costly process. According to the United Nations, simple registration of births and deaths is complete or fairly complete in only 50 countries, which corresponds to less than one-third of the world population.
[69] 34th WHA, May 1981, Official Records WHA34.1, section VII, para.6.

like, excluding hospitals. The percentage considered "reasonable" will be arrived at through country studies.
5) *Resources are equitably distributed*, in that the per capita expenditure as well as the staff and facilities devoted to primary health care are similar for various population groups or geographical areas, such as urban and rural areas.
6) *The number of developing countries with well-defined strategies for health for all, accompanied by explicit resource allocations, whose needs for external resources are receiving sustained support from more affluent countries.*
7) Primary health care is available to the whole population, with at least the following:
- safe water in the home or within 15 minutes walking distance, and adequate sanitary facilities in the home or immediate vicinity.
- immunization against diphtheria, tetanus, whooping-cough, measles, poliomyelitis, and tuberculosis;
- local health care, including availability of at least 20 essential drugs, within one hour's walk or travel;
- trained personnel for attending pregnancy and childbirth, and caring for children up to at least 1 year of age.
8) *The nutritional status of children is adequate*, in that;
- at least 90% of newborn infants have a birth weight of at least 2500g;
- at least 90% of children have a weight for age that corresponds to the reference values given in Annex 1 in this volume.
9) *The infant mortality rate for all identifiable subgroups is below 50 per 1000 live-births.*
10) *Life expectancy at birth is over 60 years.*
11) *The adult literacy rate for both men and women exceeds 70%.*
12) *The gross national product per head exceeds US$ 500.*

Establishing a comprehensive system to collect and evaluate statistical data on health on an international basis was an important and essential development for health. By establishing an internationally compatible system, the world at last has access to fundamental information on the status of world health. It certainly bolsters the position of the WHO within the UN system because it is difficult to develop effective international health policy without accurate, globally compatible statistical data. Such material certainly has broad application outside the Health-for-All programme even if some data is type specific. Importantly, it shows that it is possible to measure health. This has clear ramifications for the right to health, which has been stifled on the grounds that it is not possible to quantify alleged violations of that right.

Unfortunately, the list of 12 global indicators is not mandatory so there is no legal obligation on states to collect and provide the necessary data. There is also no way to confirm the accuracy of material provided. The use of statistics to monitor, assess and evaluate health policy is important, but its results can be deceptive if not considered in context. As the WHO already experienced, there are difficulties in trying to formulate a globally comprehensive system when it is difficult to objectively determine health status. Still,

establishing globally compatible data on many elements of health is an essential step in the process of determining social and legal rights in relation to health.

### 3. The benefits of the Health-for-All policy

The impact and benefits of the Health-for-All policy on the WHO have been substantial. Health-for-All was the organisation's first move toward a holistic view of health by shifting away from the medical model to a more socio-ecological model. This shift was significant as it highlighted the distorting effect of a curative approach to medicine that had slowly pervaded the WHO's other policies. A further benefit of this shift in approach has been the commitment to communicate and co-operate with other international bodies working not only in the field of health *per se*, but also in the broader arena of development and finance. Having a more over-arching policy on health certainly provides a measure of consistency and direction. The concept of long-term thinking about health shows that a more co-ordinated and effective approach to health can be developed and refined as necessary. A coherent strategy, rather than a piecemeal or ad hoc approach, has the additional benefit of enabling greater evaluation and accountability within the organisation. However, the biggest boost probably came from the overwhelming declarations of support from states at the Alma-Ata Conference and afterwards. This level of international consensus led to the development of a set of universal principles, which according to Dr. Antezana, allowed Health-for-All to become a global rallying-point for improved health.[70]

Health-for-All recognised the importance of social justice and equity to health. In so doing, it allied itself more closely with the human rights movement and moved away from a technical medical approach.[71] The consequences for health policy was the preferential allocation of resources to people at the social periphery in order to fulfil the social goal of making essential health care available to all. Resolution WHA45.4, May 1992, advocated that governments review and redefine their role to ensure universal access to integrated health services of acceptable quality, with particular emphasis on health promotion and disease prevention.

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[70] Assistant Director General, Official Records, 49th WHA, May 1996, A49/B/SR/2 - provisional summary record of the second meeting at p.7.

[71] Curtis and Taket, however suggest that this is a strategy based on a synthesis of the cultural / behavioural and materialist / structuralist explanations for ill health, aimed for a balance of emphasis on individual and collective responsibility for health.
Curtis and Taket (1997), p.260.

This was to be accomplished through a new inclusive framework of public health action rather than focusing simply on techniques to reduce the birth rate and infant mortality rate.[72]

Furthermore, there was recognition that states could not achieve such aims without interstate communication and support. Recognition of the global nature of health led to an important change of approach at the international level with the recognition of the relationship between health and development and the consequent need to co-ordinate between health and other sectors. This broadening of focus should also result in the reduction of the isolation of the WHO within the international arena if it is seriously acted on.[73]

## 4. Problems with Health-for-All policy

The 1988 review of Health-for-All recognised five critical challenges hampering its progress. These challenges were:

- to sustain commitment to resolve social inequities, resolve operational difficulties and expand people's responsibilities for their own health;
- to intensify efforts to expend managerial capacities, including sound policy decision-making and focusing on priorities and targets based on valid information;
- to intensify efforts to strengthen health infrastructure based on the principles of primary health care;
- to manage all available health resources well while mobilizing additional resources;
- to provide support to the least developed countries on an unprecedented scale. [74]

In addition, in my view, three fundamental problems concerning Health-for-All were not recognised. They were:

- Lack of structural integrity
- Misaligned content; and
- The theory/practice gap.

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[72] 45th WHA, May 1992, Official Records WHA45.4, 'Implementation of the global strategy for Health for All by the year 2000, second evaluation; and eighth report on the world health situation.'

[73] Philip Alston has been one of the leading critics of the WHO's failure to support and communicate with the Committee on Social, Economic and Cultural Rights.
See such articles as:
Alston, P. (1979): Making and breaking human rights: the UN's specialised agencies and implementation of the International Covenant on Economic, Social and Cultural Rights; and
Alston, P. (1979): 'The United Nation's specialized agencies and implementation of the International Covenant on Economic, Social and Cultural Rights'. Vol.18 Columbia journal of transnational law, pp.79-118.

*Lack of structural integrity*

"The one most important factor missing in PHC and the health-for-all concept is the *political will.*"[75] Unfortunately, the WHO's programme is dependent on goodwill pre-dominantly focused at the ministerial level. Health, however, is generally not a major ministerial portfolio and so remains only one among many national and international obligations vying for resource allocation.[76] Governments and policy makers are also unlikely to hold themselves accountable either to their populations or the wider community in health matters. Instead, they are more likely to highlight health policy that reflects their position most favourably and to adopt fragments of overall health policy accordingly.[77] The Health-for-All policy easily accommodates such a position, particularly with the unfortunate development of à la carte primary health care. Rather than requiring countries to adopt the whole programme and thereby maintain the structural integrity of the Health-for-All programme, the WHO preferred to cajole and coax rather than utilise its powers.[78] Would a deadline for formulation of policies have been useful?[79] The WHO's Regional Office for Europe felt that it would, but such a deadline would reflect a fundamental change in attitude on the part of the WHO.

Unfortunately, for purposes of adoption of the Health-for-All programme as an integrated whole, two important initiatives, the formation of the Global Advisory Council and the intensified Support to Selected Countries, did not survive.[80] The Global Advisory Council was to be an independent mechanism to

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[74] Implementation of the global strategy for health for all by the year 2000: 8th report on the world situation, global review, (1993), p.160.

[75] Mburu, F. (1980): 'A critique of John H. Bryant's paper.' Vol.14A Social science and medicine, pp.387-389, p.389.

[76] A reality recognised by the WHO in Official Record EB95/15 which states that the political position of putting primary health care into operation has turned out to be much more complex, difficult and exacting than had been foreseen.
[Executive Board, 95th session, November 1994, EB95/15, 'Reviewing the Health-for-All strategy. Report by the Director-General.']

[77] Rathwell, T. (1992): 'Realities of health for all by the year 2000.' Vol.35 Social science and medicine, pp.541-547, p.545.

[78] Mburu believes that "it is too much to expect that PHC will *revolutionise* the health of the majority of the people in the poor areas without a *conceptual* revolution among policy makers in health and other areas but resistance against such a revolution is too much with the attractiveness of the status quo is too numerous."
Mburu (1980), p.388.
For detailed analysis of the legal powers of the WHO see chapter 7.

[79] WHO Regional Office for Europe, (1982): Primary healthcare - from theory to action. Report on a WHO symposium, p.8.

[80] A joint UNICEF/WHO project was developed of intensified support to selected countries which were felt to be incapable of attaining the goals of Health-for-All without strong support. Initially 10 countries were chosen but this was later reduced to 5 but with limited results. The political commitment and co-

monitor progress towards Health-for-All and to determine the adequacy of the support provided by the WHO, UNICEF and other relevant agencies. The Council was to suggest remedial action to the Director-General, and through her/him to the governing bodies of other organisations. In the end, the WHA feared that the Council would only duplicate the work of the Executive Board.[81] As a result, the WHO has been left with no mechanism, other than political rhetoric, to exert pressure on the various parties who make commitments in relation to Health-for-All.

As has been noted, Health-for-All's implementation was left to the discretion of state parties with little formal direction. The Alma-Ata Declaration makes no reference to preferred legislation or legal methods. However, it is difficult to envisage how such a programme can be comprehensively implemented without a legal framework institutionalising the goals of Health-for-All. Relatively few states took the initiative to adopt enabling legislation to enhance the implementation of 'charters' and other expressions of commitment to primary health care.[82] This lack of a legal framework at all levels was extremely unfortunate. Taylor believed that the failure of Health-for-All was largely due to a failure to effectively use legal strategies such as the creation of national and international law and supervisory institutions to advance the programme.[83]

This omission was acknowledged by the WHO in its 1993 report, which stated "[i]t was generally recognised that such an ambitious goal as Health-for-All could not be achieved in the absence of an up-to-date, enlightened, and reasoned framework of laws, regulations, and other instruments that make clear the responsibility of the state, other national and subnational authorities, members of the health professions,

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operation in the face of diversity of interests and the range of political, economic and social uncertainties had been grossly underestimated. "Thus the idea that PHC can work through intensified global effort in selected countries within a short time frame seems to be false."
Tarimo and Webster (1997), pp. 57-58.

[81] Ibid., p.57.

[82] Ibid., p.27.

[83] Other pertinent factors that had a negative impact on the Health-for-All programme were the world economic decline, an inadequate national concern in health, the low priority of health for domestic elites and the fact that the programme was too radical for conservative doctors to endorse.
Taylor, A. (1992): 'Making the World Health Organisation work : a legal framework for universal access to the conditions of health'. Vol.XVIII No.4 American journal of law and medicine, pp.301-346, particularly at p.326.
Her assessment has since been endorsed by Fidler, D. (1998): 'The future of the World Health Organization: What role for international law?' Vol.31 Vanderbilt journal of transnational law, pp.1079-1126. This article goes on to advocate the establishment of a department of international law within the WHO.

and different elements of society concerned with health development".[84] Health legislation could also be used in a variety of areas, in addition to supporting national health policies and strategies. The list includes:

- to support basic human rights (including the right to health, patients' rights, issues related to discrimination);[85]
- to support changes in the health system and in health care financing and power development;
- to support environmental health policies;
- to promote healthy life styles (e.g. consumer goods meet prescribed safe standards); and
- to support and control new technology (reproduction, genetics, organ replacement, etc).[86]

The report, however, only considered the merits of legislation at a national level. While this is certainly an important arena in which to effect change, it also suggests that the WHO continues to ignore the potential of international law. Another fundamental structural flaw in the Health-for-All programme was the WHO's failure to adequately consider the impact that existing power relations within society have on health. Most improvements in health have been due to changes in economic, social and political structures rather than action taken in the health sector. The WHO should be developing policy to build on this relationship.

The strangest structural flaw in the Health-for-All strategy was the lack of a clearly defined role for the WHO. Throughout the programme, the focus of reform was at state level with the WHO acting as facilitator on request. The organisation seems to have adopted a managerial approach in which it compiled and distributed information and made tentative efforts to evaluate general policy initiatives. By adopting this approach, the WHO avoided responsibility for the implementation of its policy and minimised its accountability. Such a position is very limiting and did little to enhance the position of the organisation within the international arena. Instead, the WHO needed to adopt a more critical, pro-active stance on health in order to gain an effective voice on the international stage.

*Misaligned content*

While some have unjustly dismissed primary health care as 'poor care for poor people' it is easy to see how the policy can be so misrepresented and misunderstood. Any system of health trying to have meaning for the entire world population faces difficulties, and the situation has been aggravated by vagueness. It remains unclear whether the Alma-Ata Declaration was to establish a new philosophy, strategy and level

[84] Implementation of the global strategy for health for all by the year 2000: 8th report on the world situation, global review, (1993), p.55.
[85] Note that the report considers that Health-for-All and the right to health are separate entities.

of health care or to simply be a set of activities to be undertaken. Certainly, the Health-for-All programme has been influential not only within the WHO but also within the field of international health. It would seem reasonable to suggest, despite rhetoric to the contrary, that Health-for-All built on the medical model of health. Little consideration was given to the social welfare element of health. By again striving to remain apolitical, the WHO merely politicised health issues in a monotheistic way – curtailing essential debate.

Linked to this failure to articulate an underlying philosophy was the lack of convergence between the various recommendations found in the Alma-Ata Declaration. This inability to visualise a coherent, intrinsically linked programme enabled the adoption by countries of selective primary health care.[87] To exacerbate the problem, there were no clearly defined aims established for primary health care. Instead, each country was to develop its own agenda to satisfy its own problems. Although it was necessary to enable each state to personalise its health programme, without a clear articulation of expectations, gross assumptions had to be made as to the basic knowledge and level of understanding concerning primary health care of those implementing the policy. Such assumptions resulted in confusion and a range of definitions and approaches to Health-for-All.

> "In spite of this clear policy mandate, the implementation of the Alma-Ata recommendation has been a slow process in industrialized countries. One of the main reasons is the concept of primary health care itself, its poor definition and a lack of analysis of its implications for industrialized countries. More often than not, the concept is understood too narrowly. It is either considered to be relevant for developing countries only or it is identified with the primary medical services of the industrialized countries."[88]

Such divergence of approaches occurred not only at the national level but also at the international level. This unfortunately meant "the gap between the acceptance of the principles of global solidarity of the Alma-Ata conference and other conferences and the implementation of those principles is enormous".[89]

*The theory / practice gap*

> "However, a more analytical look at the situation suggests that the biggest single factor behind this inability to translate rhetoric into reality is total lack of public participation in the governmental and intergovernmental process that are supposed to implement declarations of this

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[86] Implementation of the global strategy for health for all by the year 2000: 8th report on the world situation, global review, (1993), p.55.
[87] Tarimo and Webster (1997), p.66.
[88] Implementation of the global strategy for health for all by the year 2000: 8th report on the world situation, global review, (1993), p.2.
[89] Tarimo and Webster, op. cit, p.60.

> kind. It was all left to politicians and "experts". Ordinary people, on whose behalf the Declaration concerning health for all was made, were involved neither in its formulation nor in its attempted implementation."[90]

This was Pamphil Kweyuh's assessment in his contribution to the renewal of the Health-for-All strategy. It is difficult to imagine the WHO of 1978 undertaking the kind of participatory dialogue for which he argues. Despite the prominent role advocated for broad-range participation in the Alma-Ata Declaration, the WHO itself is still struggling to establish an effective method of facilitating comprehensive consultation. It should, therefore, not be surprising that little progress has been made in this area at national level.[91]

As noted above, evaluation of Health-for-All policy is severely hampered by the lack of adequate information on even the most critical indicators.[92] This is in part due to a failure by states to collate and provide data, as well as the problematic nature of collection in some countries. The indicators that do exist point to retrogression rather than progress in health.[93] Mburu suggested that Health-for-All did not result in improved availability or accessibility to health care for the majority of the poor.[94] But the quality of care received may be have been lower because of reduced resource input. The WHO acknowledged these difficulties and placed a measure of blame on the inadequacy of the 'global health machinery' but also recognised that changes to the Health-for-All programme have to be made.[95] Partly as a reaction to these problems, other international organisations such as UNICEF and the World Bank started to shift away from the Health-for-All approach to health.[96] This was unfortunate, because it again isolated the WHO.

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[90] Kweyuh, P. (1996): 'Health for whom by when? A view from Kenya.' Vol.17 World health forum, pp.346-347, p.346.

[91] Kweyuh went on to recommend that opportunity be given for ordinary people to discuss their aspirations, fears, experience and health activities and that the radio may be the appropriate medium by which this could occur. Certainly, this is a necessary step but it is only the first step in the process towards real community participation where the local people have a role in the decision making process and assist in evaluation and assessment of policy.

[92] Koivusalo and Ollila (1997), p.123.

[93] Tomasevski, K. (1995): 'Health rights' in Eide, A., Krause, C. and Rosas, A. (eds.) Economic, Social and Cultural Rights: a textbook, pp. 125-142, p.129.
According to a WHO assessment at least 26 countries will not be able to reach Health-for-All just using the indicator of under-five mortalities. Tarimo and Webster (1997), p.53.

[94] Mburu (1980), p.389.

[95] World Health Organization, (1988), particularly p.65.

[96] UNICEF has promoted its own version of selective primary health care while the World Bank has become more involved in the public and private differentiation in health services and personal responsibility in health.

More importantly, it resulted in the re-fragmentation of global health: a position that can only result in confusion and contradictory policy at the grassroots level.

While it is clear that there were numerous problems with the Health-for-All programme, it is important to remember that the Alma-Ata Declaration was the first to offer guiding principles in the sphere of international health systems, and it has been very influential in the development of the right to health within the human rights field. Few dispute the desire to attain universal access to appropriate and affordable health care, but there is severe disagreement as to the health service that meets these criteria and even disagreement as to the terms themselves. As a result, there was an attempt to revise the Health-for-Al programme.

### C. Revision of the Health-for-All strategy

#### 1. The World Health Declaration

In May 1995, Resolution WHA48.16 requested the Director-General:

> "to take the necessary measures for WHO to secure ... high level political endorsement of a health charter based on the new global health policy, in order to obtain political ownership of the policy and commitment to its implementation."[97]

In conjunction with its 50th anniversary, the World Health Declaration was adopted under Resolution WHA51.7, May 1998.[98] Unfortunately, the resulting declaration is something of a disappointment in that it fails to address many of the concerns and criticisms levelled at the Alma-Ata Declaration and is uninspiring particularly when compared to the draft version originally submitted to the Executive Board.[99]

Article I of the World Health Declaration reaffirmed that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" but expanded this concept further by

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[97] 48th WHA, May 1995, Official Records WHA48/1995/Rec/1, WHA48.16, 'WHO response to global change; Renewing the Health-for-All strategy.'

[98] 51st WHA, May 1998, Official Records WHA51.7, 'Health-for-All for the twenty-first century.' This Declaration was adopted "in the sense of Article 23 of the Constitution..." In so doing, this Declaration, unfortunately, only has the legal authority of a recommendation. As such Member States are simply required to submit an annual report on the action taken with respect to it (to be in compliance with Article 62). For further discussion see Chapter 7.
The EB made the decision to implement in this manner rather than opting for the alternative which was to utilise Article 19 to invigorate this new approach with the status of a convention and consequently invoke the weight of international law.

[99] Executive Board, 101st session, December 1997, Official Records EB101/9, ''Health-for-All policy for the twenty-first century.'

affirming "the dignity and worth of every person, and the equal rights, equal duties and shared responsibilities of all for health". In so doing, there is a heavy emphasis on equality in terms of rights and obligations but with a suggestion of individual responsibility as well. Equity, solidarity and social justice have become key components of the rejuvenated 'Health for All policy for the Twenty First Century,' and these principles are set out in Article II. That Article also contains a commitment to incorporate a gender perspective in health strategies. Importance is placed on the need to reduce social and economic inequalities as part of the process of improving the health of the whole population, but the methods advocated simply reiterate existing primary health care policy.[100]

These same principles are then reiterated in Article III. There is, however, greater emphasis on the need for an effective health system, which should include "essential public health functions and services in order to ensure universal access to health services...". Such services are to be "based on scientific evidence, of good quality and within affordable limits, and that are sustainable for the future" and is to be achieved through the "appropriately managed public and private actions and investments for health".[101] The final Articles, IV and V, simply reaffirmed the interdependence of the world and reasserted the need for global co-operation and support.

Despite the heralding rhetoric prior to the adoption of this declaration, there is little change in direction or approach that suggests any major deviations from pre-existing Health-for-All policy. The WHO seemed to be struggling to formulate a new identity for itself despite clearly recognising the need to do so. A number of interesting proposals that appeared in the draft document presented to the Executive Board regretfully did not find inclusion in this final draft.[102] I speculate these were dropped, because they were more controversial, and consensus was considered more important for a 50th anniversary celebration. Certainly an important opportunity was missed.

[100] Emphasis is placed on the need to focus first on the needs of "those most in need, burdened by ill-health, receiving inadequate services for health or affected by poverty" and health is to be promoted by "addressing the basic determinants and prerequisites for health".
[101] In so doing the WHO is seeking to incorporate the World Bank's current policy on health.
[102] And as a result were not offered as an option to the WHA.

Among the deleted articles were a definition of health,[103] greater recognition of a social component to health,[104] emphasis on the 'spirit of solidarity', a more dominant role for legislation, and moves towards greater accountability. 'Equity, solidarity and social justice' were considered to be the key components of the WHO's approach to health for this century but in the declaration only the concept of equity was elaborated upon. The draft declaration considered it important that "all who provide human, technical, material and financial resources make them appropriate and sufficient to meet the priorities in a spirit of solidarity" (Article VII) and that in carrying out these actions and responsibilities "their solidarity is mutual and each is responsible for all" (ArticleVIII). This suggests an important political shift in approach that needed to be more clearly highlighted in the final declaration. Not only does this reflect the shift in international health towards universality and globalisation of health but also suggests responsibility must apply in a similar manner.[105]

Legislation was to play not only a more expansive role in health in the next century according to EB101/9 in relation to the implementation of policy (ArticleVII), but also in the formulation of policy particularly with regard to health and biomedical ethics, gender sensitivity, respect for cultural and spiritual values, concern for the benefit of the individual, and opposition to violence, development, trade and environmental policies and practices that impact on health and health services (Article IX).[106] While the topic is covered in the accompanying report, it was not mentioned in the declaration itself. Perhaps, this positioning can be justified as being a technical issue better considered in context.

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[103] The notion of 'basic determinants and prerequisites for health' was given substance in Article II of EB101/9 and the list of contents provided was certainly broader than earlier versions of primary health care. Included were: "*peace and security*; *equitable economic growth*; *sustainable use of resources* and a healthy environment including adequate and safe water and food as well as clothing and shelter; *equal opportunity for participation in economic and social life based on the empowerment of women and men*; education and literacy; health promotion and information to ensure healthy lifestyles; control of disease and ill-health; and essential health care of adequate quality including reproductive health care; in ensuring these prerequisites, due respect will be shown for the *culture*, *beliefs*, *right to privacy* and *autonomy of persons*" (emphasis added).

[104] Article III of EB101/9 advocated community participation as a means of mobilising societal forces towards health action. In so doing, there is an acknowledgement of the need to affect the power balance of existing social structures to improve health and as such the adoption of a more overly political approach to health.

[105] This certainly is a shift in position for the WHO with regard to the notion of independent sovereign states.

[106] Official Records EB101/9

In my view, however, the most unfortunate omission in the final declaration was the issue of accountability. EB101/9 in Article VII sought to make donors and donees accountable for policy aims and actions reiterating the importance of solidarity and mutual responsibility (Article VIII).

It is difficult to comprehend the decision to omit so many important issues from the World Health Declaration. The resulting document sadly fails to meet the objective of establishing a more sharply defined mission statement for the WHO. Indeed, the weakness of the final World Health Declaration failed to represent the much broader attempts at consultation that preceded its formulation and the accompanying implementation report.

***The consultation process***

The consultation process was considered an important tool not only to obtain information and create debate but also to create a new broad base of commitment for the revitalised Health-for-All policy. In order to achieve all these objectives a wide-reaching process was envisaged.[107] Initial work focused on development of individual country consensus statements to arise from broad based consultation using country representatives or regional offices to identify appropriate bodies such as planning commissions and other bodies concerned with policy and economic development as well as government bodies.[108] The resulting paper was then to be "discussed by national decision-makers, technical experts and representatives, politicians, NGOs, religious leaders, business and trade-union leaders, other formers of opinion and the general public". If the country received external support for health, their input was also envisaged.[109] This process was to lead to the formulation of a country consensus statement, which was to form the major element of feedback to the WHO. The time frame for this ambitious and exciting process was too short, namely three years, and the fundamental objectives of the initial discussion paper were unclear. Furthermore, there was no evaluation strategy on which to base further recommendations. It also remained unclear how the initiatives taken at different levels were to be formulated into one paper and

[107] The framework for the consultation process was established in Official Records EB95/15 and endorsed in its entirety by the Executive Board, EB95.R5 [Executive Board, 95th session, Official Records, 'WHO response to global change: Renewing the Health-for-All strategy.'] and the World Health Assembly in WHA48.16 [48th WHA, May 1995, Official Records WHA48/1995/Rec/1, 'WHO response to global change: Renewing the Health-for-All strategy'].

[108] This process was in addition to discussion involving the UN system, international organisations and NGOs.

[109] Official Records EB95/15, pp.26.80 & 81.

Member States seem to have been unclear as to their role in the process.[110] It remains uncertain how the final document was arrived at but suffice it to say that the basic strategy remained as outlined in EB95/15. However, one thing is clear, Health for All in the Twenty First Century certainly did not become a topic of public debate.

It was an extremely difficult consultation project to undertake in such a short period of time without any pre-established means of initiating dialogue and obtaining feedback. However, the desire to reach beyond international and national levels of debate is to be commended. Now that such an approach has been tested, it can be evaluated and revised accordingly. At the very least, it shows that the WHO has the necessary structure and organisational ability to orchestrate a dialogue loop to the local communities and grassroots organisations.[111] My only concern is that the exercise was more concerned with establishing a grassroots commitment to Health-for-All and a mechanism to forward the implementation strategy than to actually obtain opinions and perspectives.

**2. The new direction as formulated in Health for All in the Twenty First Century**

Resolution WHA51.7, May 1998, adopted the substantive content of Health for All in the Twenty First Century. It is a programme designed to have a 25-year horizon although assessment, evaluation and necessary modifications have been timetabled at 10-year intervals.[112] The new Health for All in the Twenty First Century vision is based on key values of:

- Recognition that the enjoyment of the highest attainable standard of health is a fundamental human right;
- Ethics: continued and strengthened application of ethics to health policy, research and service provision,
- Equity: implementation of equity-oriented policies and strategies that emphasize solidarity; and
- Gender sensitivity: incorporation of a gender perspective into health policies and strategies.[113]

It seems that the WHO is seeking to develop a philosophy of health to extend beyond any single programme as it is advocated that these values be "incorporated into all aspects of health policy, influencing policy choices, the way those choices are made, and the interests they serve".[114] With these

[110] All these are criticisms were expressed by Ms. Lobbezoo (Netherlands) in 49th WHA, May 1996, Official Records A49/B/SR/2 - provisional summary record of the second meeting.
[111] I would assert that some modifications are necessary; see Chapter 6.
[112] Official Records WHA51/7.
[113] Official Records A51/5, Chapter 3.31.
[114] Ibid.

values underpinning policy the express goals for Health-for-All are: an increase in life expectancy and in the quality of life for all; improved equity in health between and within countries; and access for all to sustainable health systems and services. To this end, specific global Health-for-All targets have been set for 2020.[115] The global targets adopted are based on the global consensus achieved at various World Conferences convened over the last decade.[116] Generally, these targets are interesting because they are more precise, purport to be based on evidence and are global in nature.

One wonders if this is the first move to develop an international fundamental minimum measure of health? These targets could be developed to have such a function, but the language used suggests that compliance is again not mandatory.[117] They have an aspirational quality about them and maintain a strong medical model influence that could serve to deflect the organisation in the longer term.

i) *The role of primary health care*

The eight essential elements of primary health care are reiterated and remain central to this revised Health for All in the Twenty First Century approach.[118] However, the articulated perception of Health-for-All in the Declaration of Alma-Ata is different from earlier WHO statements and work on the subject. There seems to be a desire to reshape the past.[119] While this is an understandably attractive proposition, it can

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[115] These are in addition to the national targets, which each state is responsible for adopting as appropriate for their particular needs.

[116] This approach suggests a growing awareness and integration with the wider international community and is an exciting development for the WHO.

[117] This document seems rather to envisage a 'partnership' and ultimately 'ownership' of this health policy. "Evolving opportunities and the reality of an uncertain future require that HFA be seen, not as a blueprint, but as a commitment to working together in pursuit of a shared vision."
[Official Records A51/5, Chapter 3.30.]

[118] It is advocated that this minimum be extended to include expanding options for immunisation; reproductive health needs; provision of essential technologies for health; health promotion; prevention and control of non-communicable diseases; food safety and provision of selected food supplements.

[119] WHA Official Records A51/5, Chapter 1.4 states:

> Health-for-All was conceived as a process leading to progressive improvement in the health of people and not as a single finite target. It can be interpreted differently according to the social, economic and health characteristics of each country. However, there is a baseline below which no individual's health in any county should fall. *All* people in *all* countries should have a level of health that will permit them to work productively, and to participate actively in the social life of the community in which they live. **Health-for-All acknowledges the uniqueness of each person and the need to respond to each individual's spiritual quest for meaning, purpose and belonging**. At the same time, **HFA is a societal response that acknowledges unity in diversity and the need for social solidarity**. Our common humanity, and responsibility for current and future generations, demand that we embrace HFA (emphasis in bold added).

I would suggest that in reality this purported definition of Health-for-All is in fact a new definition that forms an important part of Health for All in the Twenty First Century. It contains some important and

lead to confusion as it makes it more difficult for states to distinguish the focus of the new approach. States may feel that having moved to implement Health-for-All, there is no need to consider the (important) shift in focus that underpins the approach of Health for All in the Twenty First Century.

Equitable access to primary health care is considered to be an essential component of a sustainable health system in which comprehensive quality health care is made available throughout the life span rather than primarily focused on women and children.[120] Essential health system functions have also been identified to complement and support primary health care. These include the prevention and control of disease and health protection; promotion of legislation and regulations in support of sustainable health systems and development; promotion of research and fostering of science and technology in health; building and maintaining human resources for health; and securing adequate and sustainable financing.[121] Health systems that are developed in conformity with Health for All in the Twenty First Century need to be sustainable and to meet the needs of the people. Primary heath care services are designed as an individual's first level of contact with the national health system in an attempt to bring health care as close as possible to where people live and work. Primary health care should be made up of community-based and comprehensive health systems linked closely at all levels to social and environmental services to form an integrated referral system. An integral part of such a development remains the endorsement of community participation to policy development, but how such policies are to be implemented remains vague.[122]

Certainly, a lot more emphasis is placed on the social aspect of health, and the means of ensuring strong links between health and development are outlined but the social, political, economic and health impacts of power structures in society are a continuing omission. Furthermore, the lack of definitions and continued endorsement of the selective approach to primary health care hamper consistent policy implementation policy. The outlined programme is progressive and positive in its generality but continues to lack essential solutions to effectively facilitate the implementation and monitoring of sustainable health care systems. There is little that can be called innovative, rather it is an expansion of the principles found in Health-for-

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exciting principles that unfortunately may go unrecognised because of the way the report has been structured. Indeed, is this definition any different from that of the right to health?

[120] WHA Official Records A51/5, Chapter 7, paras 79-93.

[121] Ibid., Chapter 7.

[122] Ibid., Chapter 4. para.47.

All and an attempt to shift emphasis towards international development principles and away from some of the technicalities of health care.

ii) *Impact of globalisation*

At the national level, emphasis is on development of a sustainable health care system, but there is also greater awareness of the interrelationship of national health to international circumstances. Numerous external factors such as trade, economics and the environment impact on health, particularly of low-income countries. The interdependence of populations and their health now requires reassessment of the WHO's approach.[123] In the past, it has always been extremely respectful of such notions as state sovereignty and state responsibility. Document A51/5, however, suggests a shift in perspective. Issues highlighted as requiring global action include the global burden of preventable disease; the increasing disease burden, particularly in the poorest countries and communities; global diseases and health problems that transcend national borders, and for which there are known health-sector or intersectoral solutions that require transnational approaches; and situations where the performance of public health functions is hampered by natural or man-made disasters (including conflict) or where the institutional and human capacity for action remains weak.[124] There is recognition that certain issues that impact on health are now no longer under the autonomy of the state but are subject to market forces and global political, economic and social changes. The result is a call for a greater measure of international responsibility.[125] Particular reference is made to advances in biotechnology, new information and telemedical services, and global environmental threats. It is proposed that legislation may prove to be an effective tool to deal with such issues. The idea, however, is left undeveloped except to note that the "success of these approaches will depend on political commitment, capacity-building in public health law, public support and effective enforcement".[126]

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[123] This has subsequently led the WHO to establish the Commission on Macroeconomics and Health under the chair of Professor Jeffrey Sachs. It has a two year mandate to provide new insight into the key links between better health and improved economic performance.
[Executive Board, 105th session, January 2000, Official Records EB105/2, 'Towards a strategic agenda for the WHO Secretariat. Statement by the Director-General to the Executive Board at its 105th session,' p.4.]
[124] WHA Official Records A51/5, Chapter 8 para.115
[125] How is this to be facilitated and by whom? In relation to health the debate is now focused on the notion of global governance.
[126] WHA Official Records A51/5, Chapter 7, para. 87.

More emphasis is placed on the utility of national laws that "strike a balance between individual freedoms and public needs and interests".[127] Despite earlier reiteration of the need for public participation to ensure effective policy, the power and responsibility is vested solely with health ministries and departments[128] to set 'standards and norms' and inform 'the public about their rights and responsibilities'.[129] This does not seem to facilitate public dialogue or ownership of policy.

iii) *Partnership approach*

Partnership is a strong part of the vision for Health for All in the Twenty First Century and refers to partnership at the domestic, state and international levels. By advocating partnership rather than leadership, the WHO desires to facilitate productive interaction and greater communication in health.

At the national level, there is recognition of the need to include the broader civil society in the decision-making process so as to give rise to open, accountable central government and personal ownership of policy at the local level.

> "Decentralized decision-making for health, with a broad development framework in which partnerships in the provision of services are encouraged, will help to ensure that local needs are considered. Local participatory planning, full use of local capacity and resources, and more effective collaboration in bringing environmental, social and economic services closer to people will strengthen community ownership of those services and increase their utilization."[130]

The need for partnership is considered necessary between people and institutions at all levels, but there is also consideration of the need to extend this partnership toward the private sector.[131] While the ideas as expressed are also to be found in the original Health-for-All programme, the manner used is more political and directed towards a particular notion of government.[132] But little consideration is given as to how the WHO is to facilitate such ends.

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[127] Ibid., para. 86

[128] Earlier critiques of Health-for-All policy had noted that reliance on health ministries had hindered the development and affect of the programme at national level. Hence recognition of the need to align sectoral policies for health (WHA Official Records A51/5, Chapter 6, paras. 71-74) and include health in planning for sustainable development (WHA Official Records A51/5, Chapter 6, paras.75-78). So why be so restrictive here?

[129] WHA Official Records A51/5, Chapter 7, para. 86.

[130] Ibid., Chapter 8, para.106.

[131] By so doing, the WHO is again advocating a particular approach to health and health care in an artificially neutral way. It is supporting the World Bank's strategy of health finance as opposed to other possible options such as a nationally financed health system.

The concept of partnership also extends to the interrelationship of states and the increasing need to co-operate and recognise the broader impact that state action can have. "International and foreign policy must be broader-based, with greater emphasis on international health security and its contribution to sustainable peace."[133] By using such language, the WHO is implicitly seeking to place health on the international political agenda. It is interesting to speculate whether the WHO would ever consider requesting or orchestrating the UN Security Council to act against a perceived threat to international health security and peace.[134] What impact would such an approach have on the WHO?[135] It would certainly raise more questions as to accountability in health than are provided for in document A51/5.

The fact that accountability within the health system is highlighted as an issue reflects a change in attitude within the WHO. Unfortunately, the language used is too vague to be useful and is being treated as synonymous with policy commitment. [136] If the WHO is not prepared to take responsibility for its actions it is difficult to imagine that states are going to volunteer to do so. Failure to achieve equity in health may have little to do with practical difficulties in the implementation of the primary health care approach but may reflect:

> "a failure to develop effective international mechanisms for guiding or governing implementation of principles to which the global community has agreed, and for maintaining that commitment as a code of values that is diffused throughout development policies and programmes."[137]

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[132] Some could argue that, in so doing, the WHO is promoting a western capitalist model of government but it can also be said to correspond to internationally held values contained in the ICCPR.
[133] WHA Official Records A51/5, Chapter 8, para.107.
[134] According to the UN Charter, only states (Article 35.1&2) or the General Assembly (Article11.3) can refer a dispute to the Security Council. Using the relationship between the General Assembly and the WHO, could a request be made to the Security Council to act against a threat to international health security?
On 10/01/2000 the Security Council held its first debate on a health issue as a threat to peace and security. [Press release SC/6781] The issue discussed was the impact of AIDS on peace and security in Africa. UN Secretary-General Kofi Annan said the impact of AIDS in Africa was no less destructive than that of warfare itself. By overwhelming the continent's health services, by creating millions of orphans, and by decimating health workers and teachers, AIDS was causing socio-economic crises which, in turn, threatened political stability.
The Security Council reached no conclusions but "appropriate and regular follow-up with the Council" was to be implemented [p.18].
[135] Much would depend on the health risk that triggered such action and the manner in which the situation was handled. The recent request for an advisory opinion to the ICJ on *Legality of the use by a State of Nuclear Weapons in Armed Conflict* has shown that such procedures are futile if the WHO fails to adopt a position on the issue.
[136] "Accountability for achieving Health for All in the 21st century is widely shared." WHA A51/5, Chapter 5.63.
[137] World Health Organization, (1988), p.147.

Options such as a Board of Trustees to monitor or audit international functions or an International Watch for Health and Equity with a monitoring and protection function have been proposed and rejected.[138] The notion of a Global Advisory Council, rejected in 1981, continues to be alluded to on occasion by various bodies including the sub-committee of the Executive Board.[139] To date monitoring, enforcement and protection of policy remains the responsibility of the Executive Board with the assistance of the Secretariat. This approach undermines the fundamental principles of separation of power and so far has proved itself inadequate for the task.[140] An alternative approach such as an independent Global Advisory Council or an Academy of Health does need to be developed.[141]

### 3. Subsequent action

Interestingly since its launch in 1998, Health for All in the Twenty First Century seems to have had little impact within the organisation and according to internal sources there have, in fact, been no new developments in relation to this policy.[142] With the appointment of Dr. Gro Harlem Brundtland as Director-General, the WHO seems to be shifting focus under its new leadership. The future of Health-for-All in any of its existing forms is uncertain. The new Director-General has said in relation to developing a new organisational focus that "[i]f the only change we make is to repack and simply dress up in new clothes, we will achieve little, and convince no one".[143] The intention seems to be to develop a corporate strategy with a clear message of what the organisation will do and how it will do it, which is to be based on four interconnected strategic themes:

- The need to be more focused in improving health outcomes.
- The need to be more effective in supporting health systems development.
- The need to be more impact-oriented in its work with countries.
- The need to be more innovative in creating influential partnerships.[144]

These strategic themes have been subsequently narrowed to form four strategic directions:

- To reduce the excess mortality of poor and marginalized populations.
- To effectively deal with the leading risk factors.

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[138] Ibid., p.145.
[139] Tarimo and Webster (1997), p.77.
[140] See chapter 6 for further details.
[141] See chapter 8 for an outline of my proposal for such an Academy of Health.
[142] According to an unpublished letter dated 25 June 1999 from Kei Kawabata, team coordinator, organising health systems – with author.
[143] 52nd WHA, May 1999, Official Records A52/3, 'Looking ahead for WHO after a year of change: Statement by the Director-General to the 52nd WHA, p.5.
[144] 52nd WHA, March 1999, Official Records A52/4, 'Looking ahead for WHO after a year of change. Summary of *The world health report 1999*, Dr. Gro Harlem Brundtland, Director-General,' p.5.

- To strengthen sustainable health systems.
- To place health at the centre of the broader development agenda. [145]

For the years 2002-2003 the areas of focus for the WHO to give effect to these priorities are to be:

**Health systems:** without well performing health systems, technical interventions have limited impact and strengthening health systems has to be at the heart of everything we do.[146]

**Malaria, HIV/AIDS and TB:** they are major killers; they have disproportionate impact on the lives of poor people and there are huge development stakes involved.

**Tobacco:** a major killer in all societies and a rapidly growing problem in developing countries.

**Maternal health:** the most marked area of difference in health outcomes between developed and developing countries, and in itself a key milestone in the International Development Targets.

**Safe blood:** a neglected area in many countries, and key to many dimensions of human health.

**Mental health:** a major, often forgotten contributor the growing global disease burden.

**Cancer, cardiovascular disease, diabetes and chronic respiratory diseases:** the leading causes of the growing tide of noncommunicable diseases.

**Food safety:** a problem with potentially serious economic and health consequences and an area of increasing public concern.

And finally; **investing in change in WHO:** keeping this high on our agenda in search for better results and a more inspiring and productive working environment.[147]

The basis for this redirection is said to be a re-evaluation of the Constitution with the ambition of enabling the WHO "to make the greatest possible contribution to world health through developing its technical, intellectual, ethical and political leadership".[148] The new dominant focus is to be on **'poverty and health'** with specific areas of interest identified as priorities for the immediate future. It will be interesting to follow these new developments. There have, however, been many important strategies and ideas that have come out of Health-for-All. Hopefully, these will not be lost in this re-evaluation and the striving for a

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[145] Executive Board, January 2000, Official Records, 105th Session, agenda item 2, 'Towards a strategic agenda for the WHO Secretariat.' Statement by the Director-General, p.3.

[146] The *world health report 2000* is devoted entirely to health systems. It takes a much wider perspective than the traditional annual reports in that it takes account of the roles people have as providers and consumers of health services, as financial contributors to health systems, as workers within them, and as citizens engaged in the responsible management, or stewardship, of them. It also looks at how well or how badly systems address inequalities, how they respond to people's expectations, and how much or how little they respect people's dignity, rights and freedoms.
It establishes an index of national health system performance in trying to achieve three overall goals: health improvement, responsiveness to the legitimate expectations of the population, and fairness of financial contribution.

[147] Official Records EB105/2, p.5-6.

[148] Ibid., p.3.
Clearly, the current Director-General considers the original mandate is still relevant and an effective basis from which the WHO can function within the present international health arena. Unfortunately, human

corporate identity should not negate the moral and ethical component equally essential to a leading international health organisation.

**D. What is the World Health Organisation's future role to be?**

Although the WHO was intended to be the leader in international health, it is debatable whether this potential has ever been attained. The WHO itself tends to reflect in the perceived glory of its early years, and its successful eradication of smallpox and the potential eradication of polio. In reality, the WHO has always been simply one of a number of UN organisations concerned with health and has consequently struggled to establish its identity.

As part of the movement to reform and improve the general efficiency of the United Nations, the WHO has been subject to a great deal of scrutiny and criticism in recent years. As a result, there is a substantial amount of material now available offering conclusions and recommendations on reform, but no consensus has been attained.[149] Some of these proposed reforms are concerned with fine tuning existing institutional mechanisms and management practices, but such proposals are also linked to the broader proposals concerned with improving overall health co-operation.[150] Lee has synthesised these various studies, distinguishing ten key issues or themes: constitutional reform; financing and financing management; governing bodies and governance; human resource/personnel management; leadership of the WHO; mandate, functions and activities; organisational structure; programme management; reform process; and

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rights and the right to health would seem to have a minimal role within this strategy although necessarily implicit within any consideration of 'poverty and health'.

[149] Such studies have been conducted principally by health policy professionals and include:
COWI consult, (1991): Effectiveness of multilateral agencies at country level: UNICEF in Kenya, Nepal & Thailand.
Daes, E. & Daoudy, A.(1994): Decentralisation of organisations within the United Nations system. Part III. The World Health Organisation. Report of the Joint Inspection Unit. General Assembly Official Records. 48th session.
Dag Hammarskjold Foundation (1996): Global health cooperation in the twenty-first century and the role of the UN system.
Series by Godlee, F. (1994): Vol. 309 British medical journal.
Lucas, A., Mogedal, S. Walt, G. *et al.* (1997): Cooperation for health development: the World Health Organization's support to programmes at country level. London: Governments of Australia, Canada, Italy, Norway, Sweden, and UK.
Vaughan, J., Mogedal, S., *et al* (1995): Cooperation for health development: extrabudgetary funds in the World Health Organisation. Sponsored by Australian Agency for International Development, Royal Ministry of Foreign Affairs, Norway and the Overseas Development Administration, United Kingdom.

[150] Lee, K. (1998): 'Shaping the future of global health cooperation: where can we go from here?' Vol.351 Lancet, pp.899-902, p.899.

relations with other health-sector agents. [151] This list shows the broad range of problems currently facing the WHO.

Despite all the policy development over the years, the role of the WHO has been left unspecified. Prior to the Alma-Ata Declaration, the medical model that was used resulted in a paternalistic approach to health in which the WHO was expected to solve health problems and eradicate diseases.[152] With the Alma-Ata Declaration, the action and responsibility for health was placed on the state. The WHO became the facilitator and developed management expertise in relation to the Health-for-All programme but in other areas continued to focus on technical matters.

The World Health Declaration and its accompanying documents were the first to clearly identify a role for the WHO. At last, the WHO saw its role as providing leadership to the multiple partners involved in achieving Health-for-All and by acting as the world's health advocate. There was also recognition that the organisation had the necessary mandate to take on such a role. However, because the Health for All in the Twenty First Century programme is currently on hold, it now seems unlikely that the organisation will adopt this approach. To date there is only an outline as to the re-direction of the WHO under the leadership of their new Director-General. In a report to the Executive Board, the Director-General recognised that there were practical limits to the work of the WHO.[153] Significantly, she also spoke of the Health-for-All programme in the past tense, while recognising the important impact it had had in world health,[154] and seemed to have formulated a *new* direction based primarily on information gained from the long process of

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[151] Ibid.

[152] The approach adopted was paternalistic in the sense that it was developed centrally and imposed for the perceived benefit of the local communities without local participation and consultation or consideration of cultural, spiritual or economic variables.

[153] WHA Official Records A52/3, p.4:
"World health is an immensely broad and complex area to cover. Even a global organization would lose its focus if it tries to do everything."

[154] Ibid., p.2 and Executive Board, 103rd session, January 1999, Official Records EB 103/2, 'WHO- the way ahead. Statement by the Director-General to the Executive Board at its 103rd session,' p.2.
In EB 105/3 credit is given to Health-for-All as the source of inspiration for this new approach, [para.1.] and the Director-General affirms that the new corporate strategy will continue to "reflect the values and principles articulated in the Global strategy for Health-for-All reaffirmed by the fifty-first World Health Assembly in 1998" [para.8].
[Executive Board, 105th session, December 1999, EB105/3, 'A corporate strategy for the WHO Secretariat.']

revision that took place prior to the formulation of Health for All in the Twenty First Century.[155] The new outline is to focus on poverty as a fundamental cause of ill health and to emphasise "that health gains trigger economies to grow and poverty to be cut".[156]

For the WHO, the most significant impact is the development of an agency-wide strategy that is to impact on all policy rather than the former isolated programme development. It is still to be a technical agency devoted to the support of sustainable health systems, offering its advice strategically to support the real needs of countries, but the WHO is also to:

> "work with the entire community of countries, helping them to mobilize their collective wisdom, knowledge and action for producing international public goods - such as norms and standards, sound evidence and effective surveillance - actions which benefit all."[157]

A strong motivating factor continues to be the need for the WHO to regain its position as a more significant actor in international health. The new strategy outlined to achieve this is:

- WHO needs to be seen by governments and other agencies to have a sound understanding of sectoral needs and the political and institutional context in which they have to be addressed.
- WHO needs to be a reliable source of high quality advice, and to act as a facilitator with a technically authoritative voice.
- WHO needs to possess up-to-date and relevant evidence, set relevant norms and standards and be responsive to the needs of Member States.
- WHO should be able to serve as a broker and negotiator for better health - helping to reconcile concerns and needs of Member States and external agencies that support the health sector.
- WHO should be able to help to shape the rules of engagement between governments and external agencies as well as being able to use its own limited financial resources as strategically as possible.
- WHO should be instrumental in raising international resources for emerging issues in health.[158]

This is a very impressive list of responsibilities, which seek to provide a role for the WHO in international health. Key to success is the recognition that the broad development and health agenda is too big and complex for any single agency. It is possible to lead effectively while being linked to others, providing there is an agreed division of labour and real partnerships in the attainment of tangible health outcomes. To this end, the WHO has recently been very busy cementing such relationships by actively working as the

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[155] The main lesson from the consulting process for Gro Brundtland was that the WHO needs to have a clearer understanding of the broader societal agenda.
[Official Records EB103/2, p.2.]

[156] To act as a political incentive and catalyst to effect change. WHA, Official Records A52/3, p.2.
In focusing on health and poverty the Director-General acknowledged that "[v]irtually all agencies have adopted a poverty focus in their work".
[Executive Board, 105th session, December 1999, Official Records EB105/7, 'Working in and with countries. Report by the Director-General,' para.7]. So in effect the organisation had little choice but to adopt the same approach if it was to have any hope of influencing the health policy component of UN programmes.

[157] WHA Official Records A52/3, p.6.

chair of the co-sponsors of UNAIDS, engaging in a deeper dialogue on policy issues with the World Bank, initiating new dialogue with the IMF to avoid harm that can occur to the social sectors during economic adjustments to financial crisis, establishing working relations with the WTO to ensure that health dimension of trade and globalisation is part of negotiations, upgrading the office in Addis Ababa to strengthen work with the OAU, and updating and expanding working relations with the European Union and Regional Development Banks.[159]

**E. Conclusion**

Some critics consider that the normative function of WHO is now obsolete as other prominent agencies have become more influential in this field.[160] Under pressure to reduce budgetary costs and minimise overlap with other international organisations, the suggestion has been made that WHO should reduce its operations to that of specialist, technical data collection and distribution. While the technical sector of WHO has a prestigious reputation, it would seriously limit the potential for global governance if the WHO were reduced to such a position. As discussed earlier, the visionary Constitution that established the WHO and the mandate encapsulated within it remain equally pertinent today. In contrast to other organisations such as the World Bank, UNICEF, UNFPA and UNDP, the WHO has not had to manipulate or invent an international health mandate.[161] The WHO, alone, has a broad mandate to work in the international health field and included within this is a strong obligation to develop a normative framework concerned to optimise the health of the global community. The WHO needs to establish a meaningful role for itself in the current international health arena soon in order to avoid drastic reform.

The experience gained by the WHO in developing its Health-for-All policy, the broad consultation process it undertook to rejuvenate the programme and the subsequent development of Health for All in the Twenty First Century ensures that the WHO has a broad range of expertise that would be of value to the

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[158] Official Records EB 103/2, p.7.
[159] Ibid., p.11.
[160] Such agencies include the World Bank, UNICEF, UNFPA, and UNDP. In their specialist fields professional bodies like CIOMS have gained legitimacy, as have particular regional organisations such as the European Union and the European Commission on Human Rights.
For details see the series of articles by Lee, Collinson, Walt, & Gilson, (1996).
[161] See Lee, K., Collinson, S., Walt, G. Gilson, L. (1996): 'Who should be doing what in international health: a confusion of mandates in the United Nations?' Vol.312 British medical journal, pp. 302-307.

development of a right to health. As has already been recognised, the content of Health-for-All and Health for All in the Twenty First Century significantly overlaps with that of the General Comment on the Right to Health. The WHO has also started to consider some of the limitations that result from a state only approach to health. The reduced impact of these programmes was in part due to the failure of the WHO to enforce its policy. The right to health on the other hand has been developed within the human rights system and so has within its framework an enforcement mechanism that can be utilised to bring about necessary change.

Partnership between the WHO and the right to health as defined by the Committee on Economic, Social and Cultural Rights would seem to be the obvious next step in the development of a right to health.

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They argue that these other current key players in international health do not possess a clear constitutional mandate to support and delineate their involvement in health. The result has been confusion, overlap and uncertainty within the field of operation in international health.

## 5.
## The potential opportunity for the World Health Organisation and the Right to Health

### A. What position has the World Health Organisation taken in relation to human rights?

Despite the radical and forthright declaration in the Constitution of the WHO that health is to be regarded as a fundamental human right the subsequent reaction of the organisation has been ambivalent. Certainly, it has on several occasions proclaimed the right to health without qualification but it is still difficult not to conclude that these were just hollow remarks.[1]

For the first thirty years the effective mandate of the WHO focused on two main activities. It sought to provide scientific and technical advice and concerned itself with the eradication of specific diseases such as malaria and smallpox. Little attention was given to the right to health, or human rights more generally. Projects seem to have been adopted on an ad hoc basis either as a reaction to social need or to further medical interest. Over the years, there has been no discernible underlying philosophy to augment the various programmes except a pervading desire to avoid politically controversial subjects and the establishment of a bias towards a medically based format.[2]

The WHO has not sought to influence the normative development of the right to health or human rights generally. Perhaps that is because it's early attempts were not particularly successful. The initial drafting committee for the Universal Declaration on Human Rights proposed adoption of the text found in the Constitution of the WHO but the final draft bore little relation to their definition.[3] The text submitted for consideration by the WHO to the drafting committee concerned with the ICESCR was more closely reflected in the final text but the phrase 'social well-being' was excluded.[4] The notion of 'social well-being' was considered too broad and too vague and only three of the WHO's five further recommendations

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[1] In 1970, 1977 and 1998 and also in Article 1 of the Alma-Ata Declaration.

[2] Although this proved unavoidable even establishing its membership proved problematic. Controversy accompanied, at various times, the proposed membership of the People's Republic of China, North Korea, North Vietnam, East Germany, South Africa and Palestine making the goal of universal membership, unfortunately, an impossibility. There was then the issue of non-state parties and their rights as associate members to be addressed and the controversy concerning the regional office in Alexandria to be resolved, etc.

[3] See Toebes, B. (1999): The right to health as a human right in international law, pp. 36-40 for details of the *travaux préparatoires* of Article 25 of the Universal Declaration of Human Rights.

[4] The proposal was based on the broad text of the Constitution of the WHO:

> 'Every human being shall have the right to the enjoyment of the highest standard of health attainable, health being defined as a state of complete physical, mental and social well-being.'

were adopted.[5] The WHO also had limited input into later treaty provisions that pertained to health such as CRC and CEDAW.[6]

In addition to not influencing the normative development of the right to health, the WHO has given minimal support to the various human rights treaty bodies, although more recently, the WHO sends a representative to appropriate hearings in an attempt to improve the relationship with the various treaty bodies. Unfortunately, little real dialogue or active co-operation has taken place, other than a closer working relationship seems to be developing with the Committee on the Rights of the Child. This reluctance to engage with human rights treaty bodies is surprising as the WHO did have its own internal human rights committee for a period in the 1980's even if its work received little attention or publicity. Now, the WHO is in the process of looking to expand its human rights focus with the establishment of a 'Health and Human Rights Project,' the remit and focus of which is yet to be clarified.[7]

Since the Alma-Ata Declaration reiterated the right to health, there has been a gradual increase in the use of human rights' language and terminology within official WHO documentation. This change in approach may have been influenced by the Pan American Health Organisation's report on the right to health or by Mann's innovative work within the organisation centred on HIV/AIDS or may simply reflect a broader social internalisation of rights jargon. The language may correspond more readily to human rights parlance but the practicalities of approach within the organisation have remained largely unchanged. The WHO has shown little interest in defining or advocating the right to health as an international human right.

> "The Organization undertakes little normative activity and has not been greatly interested in the normative activity of other organizations with regard to health issues. It has also given little attention to human rights issues, apparently regarding them as unduly political and not within the technical mandate of the Organization."[8]

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[ UN Doc. E/CN.4/544, 18 April 1951, p.2].

[5] See Roscam Abbing, H. (1979): International organizations in Europe and the right to health care, pp. 70-77 for a detailed overview of the *travaux préparatoires* of Article 12 of the ICESCR.

[6] Leary, V. (1993): 'Implications of a right to health' in Mahoney, K. amd Mahoney, P. (eds.) Human rights in the twenty first century : a global challenge, p.490.
For details of the *travaux préparatoires* in relation to CRC see:
Detrick, S. (1992): The United Nations Convention on the Rights of the Child; and
LeBlanc, L. (1995): The Convention on the Rights of the Child.
Concerning CEDAW see:
Rehof, L. (1993): Guide to the travaux préparatoires of the United Nations Convention on the Elimination of all forms of Discrimination Against Women.

[7] 'Draft terms of reference for HHR-STP' unpublished paper on file with author.

[8] Leary (1993), p.491.

The World Health Declaration and its accompanying documents, adopted by the WHO in 1998, suggested a change in approach. The right to health was specifically addressed. Indeed, the right to health was defined:

## THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH[9]

**What does the "right to health" imply?**

- The enjoyment of the right to the highest attainable standard of health (often referred to as the "right to health") is one of the fundamental rights of each individual to his or her own highest potential in terms of health.
- In interpreting the "right to health" it is accepted that:
  - people's biological and genetic differences may limit their health potential;
  - access to health services is a necessary but not sufficient condition for realizing the "right to health".

**The 'right to health" and human rights**

- Health is a prerequisite for the full enjoyment of all other human rights. These rights are universal, indivisible and interdependent.

**International and national policies and actions to ensure the "right to health"**

- Through adoption of international and national human rights instruments Member States assume specific responsibilities and duties to promote and protect the health of their populations by:
  - ensuring that sustainable health systems are accessible to all people;
  - promoting intersectoral action to address the determinants and prerequisites of health.

Although the document addressed the issue of the right to health in broad, general terms, the main significance is that it attempted to address the right at all. Unfortunately, there was little further discussion of the subject in the rest of the document and no attempt to relate the right to health to the Health-for-All programme or the future direction of the WHO. Again, the right to health was acknowledged but only in a token way.

According to Brundtland,[10] the current Director-General, the WHO is working to accelerate and strengthen the operational bond between its health mandate and human rights.

> "In this context, the WHO has recognized the concept of "health security," a principle which encompasses a constellation of rights enshrined in the Universal Declaration of Human Rights. It necessitates universality in health care, access to education and information, the right to food in sufficient quantity and of good quality, and the right to decent housing and to live and work in an environment where known health risks are controlled. Knowledge, freedom of choice and through various forms of societal and economic transformation, the empowerment of people to effect

[9] 51st World Health Assembly, May 1998, Official Records A51/5, Box 5.
[10] Brundtland, G. (1998): 'Fifty years of synergy between health and rights'. Vol.3 (2) Health and human rights, pp.21-25, p.23.

> desired changes in their own lives are understood as critical to move health security from theory to reality."

As a result, future developments are eagerly awaited for it remains to be seen if the emphasis that the new Director-General places on partnerships includes the existing human rights system and if so how this new approach is to function in practice.

The WHO seems to have begun to move towards a human rights approach to health within the organisation. Human rights have been designated as a crosscutting activity within the organisation. The focal point function has been assigned to the Sustainable Development and Healthy Environments Cluster, which has, in turn, placed the Health and Human Rights Unit within the Department of Health in Sustainable Development. The Health and Human Rights Unit is currently minimally staffed but Health and Human Rights Focal Points are to be established in all departments as well as a Health and Human Rights Working Group.[11] The strategy and future focus of these bodies is still being negotiated and so no formal policy has as yet gained official approval. However, from review of internal strategy documents, the WHO seems to be favouring the development of a health and human rights approach. Based on the notion that:

> "[a]ll human rights – economic, social, cultural, civil and political – are universal, indivisible and interdependent and interrelated. WHO's approach to human rights is universal and holistic, stressing the indivisibility and interrelatedness of all human rights."[12]

The WHO seems to be moving toward adoption of an umbrella approach to human rights that looks beyond any one particular treaty provision to consider human rights in their broadest context. Because the WHO is not party to any human rights treaties, it has the advantage of being able to more broadly contextualise its approach. Instead of building on a particular right it has identified instead key components such as the right to participation and the right to equality and non-discrimination as well as the rights to information, education, association and to benefit from scientific progress.[13] The WHO has also identified as key elements, the governmental obligations to respect individual autonomy, privacy and physical integrity.[14] Adoption of human rights in this manner would be an exciting development for the WHO as it would facilitate a more proactive and systematic approach to health policy throughout the organisation. It

[11] Unpublished internal strategy document filed with author.
[12] Ibid., para. 2.13.
[13] Ibid., para.2.18.

would also highlight the relationship between health and human rights so as to emphasis the broader underlying determinants of health. The other positive implication must be that the organisation is considering engaging more actively with international and regional human rights systems, which can only be beneficial to all parties. These developments can only be considered as positive, if tentative, steps toward integrating human rights within the work of the WHO.

There is a potential downside to such a broad approach to human rights, since it can be too broad to be useful or meaningful. Furthermore, there are inherent risks in the adoption of an à la carte approach to human rights. Most significantly, such an approach can be viewed as a means of circumventing specific legal obligations for organisations and states in relation to individual human rights within the existing human rights framework. This was certainly the effect when a similar approach was adopted to further the Primary Health Care programme.[15]Adoption of such a broad approach to human rights could have a significant impact on internal policy but it is difficult to envisage such generality being an effective advocacy tool or being sufficiently specific to assess health policy and practice. Similarly, it is difficult to identify and advocate health indicators and benchmarks without explicitly recognising the right to health. Most importantly, if the right to health and its detailed obligations are subsumed in the array of rights, the impact of clearly identifying and outlining the right is lost.

**B. Potential impact of the Right to Health on the World Health Organisation**

Adoption and promotion of the right to health by the WHO would have significant benefits for the organisation and would not require drastic reform. The WHO is uniquely placed within the international arena to facilitate development of the right to health by building on its existing expertise and programmes. The Health-for-All approach and its subsequent updating in the form of Health for All in the Twenty-First Century provide a firm foundation from which the WHO can develop policy to give effect to the right to health. At the same time, the right to health could be a useful tool to enable the organisation to address the increasingly complex issues currently impacting on health as well as provide the leadership in international health that is presently lacking.

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[14] Ibid.

[15] Refer to chapter 4 for details.

One of the main criticisms of the WHO is its piecemeal approach to health that tends to be reactive rather than pre-emptive. The adoption of this ad hoc approach has limited the organisation's potential role as leader in international health despite being the specialised agency of the United Nations mandated to address health issues. The direction and motivation of the WHO has been too dependent on the personality and ability of the Director-General. The corporate approach adopted by the new Director-General is clearly an attempt to address this problem through the adoption of business practices, but she has also recognised the need for a moral and ethical foundation to underpin the policy of the WHO. The right to health as defined by the Committee on Economic, Social and Cultural Rights could function well as an overarching philosophy grounded as it is in the broader framework of human rights.

As a result of adopting the right to health as its underlying ethos, the WHO would become a primary advocate of the right to health. This would lead to a greater measure of policy integration within the UN system, as the WHO would necessarily seek to improve communication and co-ordination on health policy. In conjunction with the appropriate human rights treaty bodies, the WHO would also have an important role in monitoring and protecting the right to health. To fulfil this role as protector of the right to health, the WHO would have to develop a greater level of collaborative technical assistance to states and a more critical system of analysis of state conduct.

With the adoption of its Health-for-All policy, in particular, the WHO sought to expand its mandate by moving into the broader field of health policy and the even wider arena of social policy and development. But internally, there has been continued tension between those advocating a traditional medical model for health, reinforced by strong international recognition of the organisation's technical expertise,[16] and the holistic, partnership approach to health. Adoption of the right to health would ensure a more dominant role for a holistic approach to health. To be effective in relation to the right to health, the WHO would need to adopt an inter-disciplinary approach to health that considered the broader economic, social and political aspects of health as well as the medical components of disease. Development of the right to health as the crosscutting theme of the organisation would also go some way to break down the myth that health policy is simply the objective application of appropriate science.

Because the WHO, at its outset, decided to adopt a medical model to develop health policy, research and technical services concerned to promote effective control and eventual eradication of disease, this function has probably received disproportionate attention internally. Such a dominant focus on disease control has unnecessarily limited the ability of the WHO to address broader international health concerns. The resulting isolationist approach to health has been detrimental to the international image of the organisation. But at the same time, the organisation has deservedly attained the reputation for technical excellence. The skills that have been developed to address disease control are important and would be necessary to effectively monitor the right to health. For example, development of indicators as well as collection and analysis of statistical data are essential components of monitoring and enforcing human rights.

Adoption of the right to health in this manner would also return the WHO to a position that more closely reflects its original constitutional mandate. It is unfortunate that the WHO failed to embrace a global approach toward international health because of its desire to avoid politicising health. The desire to reach beyond the limits of state sovereignty to positively impact on the individual and local community would need to be re-energised. The political element of health needs to be acknowledged if the WHO is going to have the necessary credibility to impact on the broader dialogue on health that is currently taking place. The constitutional mandate of the WHO also has the advantage of legitimising the adoption of the right to health approach and would usefully serve to validate the organisation's actions to promote and protect the right in its external relations.

McCorquodale and Fairbrother, however, go further and argue that "[w]hile only states are legally obligated to protect human rights, international institutions, especially as they are largely comprised of states, arguably also have obligations to protect human rights."[17] This argument would seem, at least in part, to be in conformity with the opinion of the ICJ. The implication of its recent advisory opinion being that a United Nations 'system' must have cohesion and conformity of approach even within the 'principle of speciality'.[18] The UN Secretary-General has made it clear that he wants to see human rights integrated into the activities of the entire UN system because "human rights are inherent to the promotion of peace,

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[16] Until tarnished by the failed malaria project (1955-1969).
[17] Ibid.
[18] This extrapolation is based on the majority judgement in the *Legality of the Use by a State of Nuclear Weapons in Armed Conflict*, advisory opinion, 1996 ICJ Reports.

security, economic prosperity and social equity."[19] At this stage, international organisations such as the WHO certainly have a mandate not to violate human rights but to suggest that this mandate currently extend to protection of human rights as well is more controversial.

The Committee on Economic, Social and Cultural Rights clearly agrees with this view that there are obligations on international institutions as part of the individual state obligation.[20] To date, through its general comments, the Committee has established a negative obligation on UN agencies involved in the promotion of economic, social and cultural rights to avoid involvement in projects inconsistent with the enjoyment of civil and political rights.[21] Furthermore, the Committee on Economic, Social and Cultural Rights has stated:

> "[a]s a matter of principle, the appropriate United Nations organs and agencies should specifically recognize the intimate relationship which should be established between development activities and efforts to promote respect for human rights in general, and economic, social and cultural rights in particular."[22]

Specifically, UN agencies are considered by the Committee to be obligated to promote the realisation of these rights through co-operation and co-ordination.[23]

There has certainly been a trend within the Committee on Economic, Social and Cultural Rights to expand the notion of obligations of UN agencies to protect the rights set out in the ICESCR. In its recent General Comment on Education, there was a clear warning that it was prepared to scrutinise policy initiatives of such organisations to ensure that the impact of policy was not detrimental to rights protected under the ICESCR.[24] It stopped short of suggesting that UN specialised agencies are obligated to adopt a human rights-based approach, but there was a strong recommendation. Moreover, in its recent General Comment

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[19] Annan, K. (1997): Renewing the United Nations: A programme for reform (UN Doc. A/51/950), 14 July.

[20] "States have a joint and individual responsibility, in accordance with the Charter of the United Nations..."
UN Committee on Economic, Social and Cultural Rights: The right to adequate food (Art.11), general comment 12. UN Doc. E/C.12/1999/5, para.38.

[21] UN Committee on Economic, Social and Cultural Rights: International technical assistance measures (Art.22), General comment 2. UN Doc. E/1990/23, para.6

[22] Ibid., para. 8(a).

[23] UN Committee on Economic, Social and Cultural Rights: The nature of states parties obligations (Art.2, par.1), General Comment 3. UN Doc. E/1991/23, para.14 identifies the obligation of international co-operation while General Comment No.12, para.40, expands this to include co-ordination as well. This position was reiterated again in General Comment No.13, para.60.

[24] UN Committee on Economic, Social and Cultural Rights: The right to education (Art.13), General Comment 13. UN Doc. E/C.12/1999/10, para.60.

on the Right to Health, the Committee on Economic, Social and Cultural Rights expressly stated that the WHO has a significant role to play in the implementation of the right to health:

> "The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance..."[25]

Even though the Committee on Economic, Social and Cultural Rights considers the WHO to have a substantive role in the realisation of the right to health, it does not go so far as to suggest the WHO also has a protective role. Should the committee start to be overtly critical of particular international policy, there will be growing pressure on specialised agencies, such as the WHO, to adopt a systemic human rights approach. As a result, by adopting the right to health as its mandate, the WHO could avoid any possible future conflict between health policy that it has developed and its responsibilities to human rights. For example, if a state, having been criticised for its over zealous programme to limit the spread of TB because it contravened the individual's right to non-discrimination, were to argued in its defence that it was simply implementing WHO policy, this would be very embarrassing for the WHO. By the WHO adopting a policy protective of all human rights, that argument would not be available.

**C. Potential impact of the World Health Organisation on the development of the Right to Health**

Work now needs to be done to build on the General Comment on the Right to Health adopted by the Committee on Economic, Social and Cultural Rights. Perhaps, a UN Conference on the Right to Health would be a useful next step to facilitate a broader debate, establish a network to enhance dialogue and dispense information. Appointment of a rapporteur to investigate the current level of right to health violations is another feasible option.

For the right to health to move forward in a coherent and consistent direction, a means needs to be found to improve the level of co-operation, co-ordination and connection between international and domestic policies because these policies are inextricably linked. There is a need for an international institution to facilitate political, economic, social, cultural and philosophical dialogues on health at all levels. There is also a need for an institution that has the power and ability to monitor progress and critically evaluate

[25] UN Committee on Economic, Social and Cultural Rights: The right to the highest attainable standard of health: Comment 14 (General Comments). UN Doc.E/C.12/2000/4, para.63.

policy to implement the right to health and establish a new level of global governance. Such a system requires utilising all available legal tools as well as political persuasion.

At the international level, there is also a need to consolidate core human rights principles on which to base global health policy. The adoption of the General Comment on the Right to Health by the Committee on Economic, Social and Cultural Rights has provided important direction. Nevertheless, there needs to be a greater measure of co-operation and co-ordination within the international system, particularly within the UN institutions, to consolidate policy and to establish a more effective system of monitoring and evaluating compliance at the international as well as national and local levels. Chapman has identified five specific requirements to enable the monitoring of specific economic, social and cultural rights.[26] These are:

1. a clear conception of the specific components of the right and the concomitant obligations of states parties;
2. the delineation of performance standards related to each of these components, including the identification of potential major violations;
3. collection of relevant data, appropriately disaggregated by sex and a variety of other variables;
4. development of an information management system for these data that would facilitate analysis of trends over time and comparisons of the status of groups within a country; and
5. analysis of these data.

The General Comment on the Right to Health goes a long way towards satisfying the first and second of these requirements, but much work remains before all of these requirements can be considered fulfilled. The Committee on Economic, Social and Cultural Rights alone is not in a position to accomplish this.[27] There is a need to establish an international monitoring institution to be a material resource for the Committee on Economic, Social and Cultural Rights. The Committee's work remains extremely important and influential, but it has limited powers and is further handicapped by inadequate financial resources and time constraints. Thus, there remains a need for a principle facilitator and advocate for the right to health with broad support and legal powers to be effective. Such an institution would act as a conduit for international dialogue and debate, collect and collate appropriate data, develop normative standards, and draft legally binding treaties with sufficient enforcement mechanisms.

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[26] Chapman, A. (1995): 'Monitoring women's right to health under the International Covenant on Economic, Social and Cultural Rights'. Vol.44 The American University law review, pp.1157-1175, pp.1158-1159.

Ideally, such an institution would have access to reports and comments of any interested organisation, and produce critical and reasoned observations as to the level of compliance of other international organisations, states, non-governmental organisations, companies and communities.[28] The traditional hierarchy and exclusivity within the international system needs to be weakened with broader participation and partnership not only in relation to non-government organisations but also to academic institutions, corporations, grassroots bodies, and interested, informed individuals. Unfortunately, with the vast increase in the number of states that are party to the UN Charter, it is difficult to envisage the necessary level of political consensus and financial commitment to establish such an institution. The best option available is to adapt an existing institution. The WHO seems to be the most obvious and most suitable choice to ensure future development of the right to health. As the specialised agency of the United Nations with a mandate to address health issues, it is uniquely placed to promote and protect the right to health. Under the 'principle of speciality,' the WHO should be asserting a leadership role to ensure co-operation and co-ordination occurs in terms of health but more particularly in terms of the right to health.[29] The WHO is already in the process of trying to develop a Health Impact Assessment Model. This would be very useful tool to enable the organisation to more constructively monitor and evaluate policy within the United Nations. Such a tool, if developed to protect the right to health, could also be extremely valuable for the development of the right.

The universal membership of the WHO also enables the organisation to exert a great deal of influence on national health policy, particularly through its access to all Ministries of Health. The WHO's proven credibility and connections should enable it to effectively assist states to fulfil their obligations under the right to health as defined by the Committee on Economic, Social and Cultural Rights. The WHO also has the expertise and systems established to collect data to monitor the conduct of states and thereby improve enforcement of the right to health. In conjunction with the Committee on Economic, Social and Cultural Rights, the WHO should also be utilising its technical expertise to develop appropriate indicators and benchmarks to assess efforts towards promoting and protecting the right to health.

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[27] UN Committee on Economic, Social and Cultural Rights: General Comment 14.
[28] Many treaty-monitoring bodies publish concluding observations but primarily on reports submitted by states and some are more critical than others.
[29] See chapter 6 for more details on the principle of speciality as outlined by the ICJ.

The WHO instigated a process of broad consultation prior to the drafting of the World Health Declaration and through its Health-for-All programme has long been a proponent of public participation in the development of health policy. As a result, it is aware of the difficulties of facilitating broad-based discussion but can build on its experience to continue to foster the energy and enthusiasm for the right to health that was instigated by the drafting of the General Comment on the Right to Health. The interest in the right to health currently remains with academics and international institutions so a way has to be found to make the concept accessible to states, communities, NGOs, multinational corporations and ordinary people.

Notions of health, ill health and the right to health are necessarily influenced by social values and as such are affected by and affect the social determinant dialectic. While this internal dynamic is an inherent feature of the social consciousness, it can be affected or influenced. It is dependent on social power relations and the relationship between the individual and society's institutions of power. Therefore, social identification with the right to health must draw on these relationships. Currently, individuals generally feel dislocated from many of their social rights, including the right to health because health status is either considered ordained or the responsibility of the state. Education relating to the empowerment of the individual could seriously impact this process, particularly if there were social institutions designated to facilitate this process. Such institutions would need to be accessible and be seen as accessible, at the local, state, regional and international levels. While the WHO could not establish such a system alone, it is strategically placed to become the principle actor by accommodating this process.[30]

Another important benefit for the right to health, should the WHO decide to become advocate and protector of the right, would be the ability of the organisation to engage in dialogue with non-state actors. As a UN specialised agency, it has an established relationship with the other UN institutions concerned with health as well as having access to all the human rights treaty bodies. Consistency of approach throughout the UN system in relation to the right to health will only be achieved through concerted efforts to communicate and co-operate effectively. The WHO already seeks to ensure that health policy has a positive impact on the individual and has developed programmes concerned to improve the health education of individuals and communities as well as seeking to facilitate a greater measure of public

participation in all aspects of health policy development. Such a process can only be achieved by having established presence at the local, regional and international level. Much of the work at local level, in particular, is already carried out in conjunction with local NGOs. The WHO already has formal agreements with a broad range of health NGOs. This relationship with NGOs is important particularly if the right to health is to be effectively monitored and promoted at the local level.

Multinational organisations are another significant body whose actions can impact on the right to health. Through such work as the instigation of the International Code of Marketing of Breast-Milk Substitutes and its essential drugs programme, the WHO has started to engage in a positive dialogue with some significant multinational organisations. The decision to facilitate the drafting of a Framework Convention on Tobacco Control also shows that the WHO is not afraid to try to limit the effect of powerful multinational organisations to protect health.[31] With the globalisation of health and the increasing economic and social interdependency, states alone may have conflicting interests that reduce their ability to engage in effective dialogue with multinational organisations. A neutral third party that has broad state support, such as the WHO, would be better positioned to promote and protect the right to health in its relations with the multinational organisations.

**D. Conclusion**

The next important steps in the development of the right to health are the need to formulate a Health Impact Assessment Model that can be used by international agencies and states to assess and evaluate policy in relation to the right to health and the development of indicators and benchmarks that monitor and evaluate obligations in relation to the right to health. Such developments can only occur with collaboration between human rights experts and health professions. The General Comment on the Right to Health adopted by the Committee on Economic, Social and Cultural Rights has provided an essential framework on which to build, but the Committee cannot continue this process alone as there are inherent risks if models or indicators are used that are not expressly designed to give effect to the right to health.

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[30] It would require few structural modifications to the WHO to accommodate such an approach. See chapter 6 for details.

[31] For more details on the Framework Convention on Tobacco Control see chapter 7.

At the same time, WHO is currently searching for its raison d'être and is viewed as simply one of a number of international organisations concerned with international health. It has important expertise and experience that would be invaluable to the further development of the right to health. Adoption of the right to health as the WHO's core principles would also resolve many internal problems for the WHO.

The WHO has the constitutional mandate to adopt such an approach and is under increasing pressure from the human rights community to facilitate human rights. It could be an auspicious time for all if the WHO were to seize the opportunity to adopt the right to health as its principle mandate. However, this is presuming that the WHO has a structure that could adapt to such a role and has the legal powers to be effective as advocate of the right to health. Without these components, the WHO will be unable to effectively respond to the enormous potential of the current situation.

PART II

## 6.
## Structure of the World Health Organisation and its relationship with the United Nations

If the WHO is to improve its international standing through the adoption of the right to health as its core principle, it must do so from within the confines of the structure imposed by its own constitution. The structural framework of an organisation can strongly impact on its ability to function and adapt effectively to a new role. Constitutional limitations or restrictions need to be accommodated because constitutional reform is a difficult and slow procedure. Furthermore, the legal relationship to the United Nations and other organisations is even more difficult to alter. Realistically, there is little point advocating that the WHO embrace the right to health if there are inherent limitations imposed by the structure of the organisation that would severely hinder the ability of the WHO to take up such a role. This chapter will, therefore, examine the present structure of the WHO and its legal relationship to the United Nations as a precursor to considering if the present structure could be adopted to enable the WHO to promote the right to health.

### A. World Health Assembly

The WHA is the principle legislative body of the WHO. It meets annually. Broad participation in the WHA is achieved through encouraging the representation of states, associate states, United Nations and other specialised agency representatives, and certain NGO representatives. Of these, however, only full members (State parties) are entitled to vote. The weighted voting system was rejected and preference was given to the principle of equality so that each Member State, regardless of size or financial contribution, has one vote.[1] This has remained a very controversial policy, particularly with the major donor states,[2] and some commentators would argue that it has led to the undermining of the system by the manipulation of the

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[1] Article 6 of the Constitution of the WHO.

[2] The increase in the membership of the WHO from 55 states to 178 in 1992 has enabled bloc voting by developing countries to strongly influence policy. From the perspective of the major donors this has led to a 'tyranny of the majority'. [Now 191 members.]
[Lee, K. and Watt, G. (1992): 'What role for WHO in the 1990s?' Vol.7(4) Health policy and planning, pp.387-390, p.388.]
Walt, however, feels that this is less true of the WHO than other specialised agencies because "on the whole, technical consensus dominated policy agendas and forays into less specialized controversial debates were relatively rare".
[Walt, G. (1993): 'WHO under stress: implications for health policy.' Vol.24 Health policy, pp.125-144, p.127.]

extrabudgetary funds.[3] (Extrabudgetary funds are funds made available by donor states for specific projects rather than being allocated via the main WHO's budget.) It has been argued that by making voluntary contributions to particular policies, donor countries have been able to control and manipulate programmes in a way that is impossible from within the formal organisational structure.[4] However, other research has suggested that this development has not undermined the policy formulation but has instead gone some way to improving accountability because the programme becomes answerable to the donor.[5]

Decisions by the WHA regarding what are considered to be 'important' questions require a two-thirds majority of the Members present and voting. According to Article 60(a) of the Constitution such important questions include the adoption of conventions or agreements; the approval of agreements between the WHO and the United Nations, intergovernmental organisations and international agencies; and amendments to the Constitution. The determination of additional categories of questions to be decided by a two-thirds majority is to be made by a majority vote (Article 60(b)).

Each state party is entitled to three representatives (one designated chief delegate) who should (though it is not obligatory) have technical competence in health "preferably representing the national health

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[3] Over the past decade a great deal of research has been conducted into reforming the WHO and the United Nations generally. Detailed analysis of their findings is unfortunately beyond the scope of this paper. Referance should be made to:
Nordic UN project, (1991): The United Nations: issues and options.
Nordic UN project, (1991): The United Nations in development: reform issues in the economic and social fields: a Nordic perspective, final report.
COWIconsult, (1991): Effectiveness of multilateral agencies at country level: UNICEF in Kenya, Nepal & Thailand.
World Health Organisation, (1993): Report of the Executive Board Working Group on the WHO response to global change, EB92/4.
Stenson, B. and Sterky, G. (1994): 'What future WHO?' Vol.28 Health policy, pp.235-256.
Walt, G. (1993): 'WHO under stress: implications for health policy.' Vol.24 Health policy, pp.125-144.

[4] Stenson and Sterky (1994); Walt (1993).

[5] Vaughan, J., Mogedal, S., *et al* (1995): Cooperation for health development: extrabudgetary funds in the World Health Organisation. Sponsored by Australian Agency for International Development, Royal Ministry of Foreign Affairs, Norway and the Overseas Development Administration, United Kingdom. Although the recommendation was made that the WHO should review the use of extrabudgetary funds and develop a policy framework for managing them to improve integration with normal funding.
The WHO is currently reviewing its guidelines on the mobilisation of extrabudgetary resources. A draft policy presented to the EB in December 1999 advocated that fund-raising should focus mainly on programme priorities as identified in the budget. This suggests that internal strategy is to influence consideration of extrabudgetary projects rather than visa versa.
[For details see Executive Board, 105th session, December 1999, Official Records EB105/9, 'Draft policy on extrabudgetary resources. Report by the Director-General'.]

administration of the Member".[6] The drafters considered it important to have a close link with the government of each Member State to ensure effective communication and co-operation. However, it is possible that reliance on national Health Ministers has over emphasised the power and strategic value of such a connection. Health Ministers have tended to have limited influence within the Cabinet of the national government and therefore have not proven to be as effective an avenue of contact with each state as had originally been envisaged. The system also provides opportunity to include non-governmental experts along with government officials although this opportunity has been sadly under utilised. This is not a structural failure, as it is the responsibility of Member States to recognise the wider impact of health issues in society, but the WHO could do more to encourage broader participation.

The WHA is concerned with the 'quasi-legislative' and regulatory functioning of the WHO in that it determines policy, although there is no clear approach as to how policy is to be determined.[7] To carry out this function, the WHA has the power to establish institutions or committees, as it considers appropriate.[8] It votes to name the Member States entitled to sit on the Executive Board, appoints the Director-General and most importantly reviews and approves expenses and apportions them among Member States (Article 56). In addition, it initiates relations with other organisations and maintains a relationship with the UN system.[9] The WHA also has the authority to adopt conventions or agreements,[10] to make recommendations to members with respect to any matter within the competence of the organisation,[11] to adopt regulations on specific questions[12] and to take any other appropriate action to further the objective of the organisation.[13]

The WHA provides a forum for ideas, policy and issues to be debated as well as an opportunity for medical experts to have access to information on the latest medical developments. In line with UN reform,

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[6] Article 11 of the Constitution.
A recommendation is being considered that will broaden slightly the criteria for delegates to the Health Assembly (52nd World Health Assembly, April 1999, Official Records A52/24, 'Amendments to the Constitution: Report by the Secretariat.)

[7] The WHA can be the setting for intense behind the scenes lobbying but generally policy is strongly influenced by the Director-General and the Secretariat.

[8] Article 18 (e) & (l) of the Constitution.

[9] It must consider and report on recommendations of the UN General Assembly, ECOSOC and the Security Council (Article 18(i)& (j)) and invite representation from other appropriate international organisations (Article 18(h)).

[10] Article 20 of the Constitution.

[11] Ibid., Article 23.

[12] Ibid., Article 21.

[13] Ibid., Article 18(m).

it has been suggested that it would be more efficient for the WHA to instead meet every two years.[14] To date this has been resisted although the budget is now only debated at alternate sessions to reduce costs. It is important that the powers of the WHA are not weakened, as it is an essential mechanism for maintaining a level of accountability within the system.

**B. Executive Board**

The Executive Board currently consists of thirty-two people designated by Member States that have been elected by the WHA.[15] When electing the Member State, the WHA is required to ensure that an equitable geographical distribution of representation is maintained and not less than three members are elected from each of the WHO's regional organisations.[16] The Executive Board's members serve for three years, and may be re-elected.[17] Importantly, each board member is to be "technically qualified in the field of health".[18] The Executive Board meets at least twice a year and determines the place of each meeting.[19] Its Chairperson is elected from among its members and the Board adopts its own rules of procedure.[20] For pragmatic, political reasons rather than to conform to any constitutional obligation, the Executive Board maintains as members, representatives of the Permanent Members of the UN Security Council.[21] There was a proposal before the WHA that sought to abolish the practice of continual re-election of Permanent Members to the Executive Board but it has not yet gained approval. The proposed amendment read "[n]o Member should have a greater right, explicit or implied, than any other Member to designate a person to serve on the Board".[22] Such an amendment could have important political and financial repercussions for the WHO, but it is certainly the necessary approach to adopt if the organisation is going to advocate a

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[14] This proposal caused much concern at the 8th meeting of the Committee on Administration, Finance and Legal Matters (21st World Health Assembly, May 1968, Official Records No. 169, pp.533-539).
Dr. Novgorodcev (Union of Soviet Socialist Republics) considered "[t]he Health Assembly had become the place for detailed analysis of medical achievements, to enable them to be used as rapidly as possible for the solution of countries' health problems" (p.531).

[15] Articles 24 and 25 establishing the EB have been the subject of several constitutional amendments and much critical review.

[16] Article 24 of the Constitution.

[17] Ibid., Article 25.

[18] Ibid., Article 24.

[19] Ibid., Article 26.

[20] Ibid., Article 27.

[21] China, France, Russia, United Kingdom and USA are always represented on the Executive Board. The representative of these Members, on expiry of her/his three-year term, is re-elected within a maximum period of one year.
[Beigbeder, Y. (1998): The World Health Organization. (International organization and the evolution of world society, volume 4), p.33.]

policy of equality. The Executive Board is not the Security Council and so no Member State should feel threatened or disempowered by not being represented.

Dr. Novgorodcev considered the Executive Board to be "the most important technical directing organ of the Organisation, the tool of the Assembly".[23] The Executive Board acts as the executive organ of the organisation and is principally responsible for ensuring decisions of the WHA are acted upon (Article 28). It also has the power to make recommendations, give advice and submit proposals for policy to the WHA. In this, the Executive Board is strongly influenced by the work of the Secretariat and the Director-General. While the Constitution established the Executive Board to implement the decisions of the WHA, the practical reality is that the Executive Board presents the policy of the Director-General to the WHA for approval.[24] The Executive Board that is responsible for reviewing all committees established by any of the organs under powers vested by the constitution. The Executive Board also represents the WHO on joint and mixed committees and it has the power to take emergency measures to deal with events requiring immediate action.[25]

The actual duties and responsibilities of the Executive Board has, on occasion, been the subject of debate. Some state parties considered that the Executive Board should simply be a technical committee, and as such, have no interest in financial matters. Others considered it to be a board of government representatives with delegated power that could loosely be said to correspond to the structure of the Security Council.[26] It was acknowledged by Dr. Van den Berg that the "principle of independence had not always been recognised and he had frequently noticed confusion not only among new Members but

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[22] As detailed in 52nd World Health Assembly, April 1999, Official Records A52/24, 'Amendments to the Constitution: Report by the Secretariat'.

[23] Union of Soviet Socialist Republics representative, 8th meeting, 21st World Health Assembly, May 1968, Official Records 169, p.534.

[24] Recommendations of the EB rarely fail to gain the approval of the WHA.

[25] Article 28 of the Constitution.

[26] See 21st World Health Assembly, May 1968, Official Records No. 169, 7th meeting of Administration, Finance and Legal Matters, p.529 at which Dr. Evang (Norway) considered

> "[t]he present move to reduce the influence of the Health Assembly and give political overtones to the Executive Board would to some extent be a parallel with the Security Council. However, a technically specialized body such as WHO has no need for a body of that type; it should be managed not by diplomats and treasury experts but rather by experts in the technical and health administration fields who were best qualified for the tremendous task of shaping world health policy."

especially among the leading nations".[27] In 1998, Resolution WHA51.26 was adopted to clarify the interpretation of Article 24 and it states that designated representatives to the Executive Board "should designate them as government representatives".[28] In some measure this clarification only fuels the debate because as government representatives, their independence can be questionable as they may feel an overriding responsibility to their national government. "In practice, it appears that Board members are more independent when their tasks are more technical, but that they tend to follow their Government's instructions or policies when debates are political."[29]

Debate has also consistently focused on the need to achieve a balance between obtaining a satisfactory relationship between size and geographical representation in the organisation as against maintaining efficacy. It also reflects the power struggle that has been a feature of the WHO as its membership has increased. The latest approved amendments (not yet in force) to Articles 24 and 25, in 1998, proposed to increase the membership of the Board from 32 to 34.[30]

**C. The Director-General and the Secretariat**

The WHA appoints the Director-General but, to limit independent action and provide a measure of accountability, the position is "subject to the authority of the Board".[31] There is no reference in the Constitution to the length of term or procedure for removal of the Director-General instead this is left to the discretion of the WHA. This approach allows for greater flexibility by avoiding the need for constitutional amendment[32] and has enabled the WHO to react to changing circumstances.[33] However,

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[27] 3rd World Health Assembly, May 1950,Official Records No. 28, 13th meeting of Administration, Finance and Legal Matters, p.390.

[28] 51st World Health Assembly, May 1998, Official Records WHA51.26, 'Review of the Constitution and regional arrangements of the World Health Organization. Status of members of the Executive Board. Clarification of the interpretation of Article 24 of the WHO Constitution'.

[29] Beigbeder (1998), p.33.

[30] Approved in resolution WHA51.23 [51st World Health Assembly, May 1998, Official Records, 'Amendments to Articles 24 and 25 of the Constitution'].

[31] Article 31 of the Constitution.

[32] The need to obtain a constitutional amendment before reform of the EB can occur has certainly hampered attempts at change. Whether this has been beneficial or detrimental to the functioning of the Board is debatable.

[33] The contract for the current Director-General was the subject of much closer scrutiny following negative experiences in the past. WHA51.5 approved the inclusion of a clause enabling the WHA to terminate the contract for "reasons of exceptional gravity likely to prejudice the interests of the Organization" (Clause I(6)).
[51st World Health Assembly, May 1998, Official Records WHA51.5, 'Contract of the Director-General.']

recently the selection and function of the Director-General has been the subject of controversy and public concern.[34]

Constitutionally the Director-General is *ex-officio* secretary of the WHA and is therefore responsible for staff appointments,[35] but it is also the Director-General that acts as the driving force and provides direction for the organisation as a whole.[36] There is a great deal of power vested with the Director-General and the Secretariat for not only does she/he establish the direction and focus of the organisation,[37] but also prepares

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[34] Dr. Hiroshi Nakajima gained a second term as Director-General despite allegations of mismanagement and financial irregularities. This re-election occurred against unprecedented opposition from every major donor nation except Japan.
Godlee, F. (1993): 'WHO at the crossroads: will it embrace the necessary reforms? Vol.306, No.6886, British medical journal, Editorial, p.1143.
The lack of public discussion or awareness of potential candidates in the election for Director-General also gave rise to criticism that the WHO lacked opacity.
Fortress WHO: breaching the ramparts for health's sake.' (editorial) (1995). Vol. 345 (8944), Lancet, pp.302-204, p.204.

[35] Article 32 of the Constitution.

[36] "Dr. Mahler is described as a visionary, a charismatic leader – "almost like a priest," said Dr. Miroslaw Wysocki, head of health information at the WHO's South East Asia Regional Office."
Godlee, F. (1994b): 'The World Health Organisation: WHO in retreat: is it losing its influence?' Vol. 309 British medical journal, pp.1491-1495, p.1492.
To be contrasted with Dr. Nakajima who was considered a compromise operator whose purpose was "to keep major interest groups happy wherever possible."
Godlee (1994b), p.1493.
A senior staff member of the WHO was quoted as saying that:

> "The WHO needs someone from outside, with good international stature who would not get too involved in micromanagement. From the Japanese point of view they shouldn't have links with the United States. And they should be a doctor and a woman."

The current Director-General, Dr. Gro Harlem Brundtland fulfils all these criteria.
Godlee, F. (1997b): 'WHO director general faces leadership challenge.' Vol.314 British medical journal, pp.998.

[37] The latest Director-General, Gro Brundtland, is seeking to re-focus the technical work of the Secretariat with the selection of four strategic directions as part of her strategy to **"enable WHO to make the greatest possible contribution to world health through increasing its technical, intellectual and political leadership"**[part of new mission statement, EB105/3, para.7]:

> **Strategic direction 1:** reducing excess mortality, morbidity and disability, especially in poor and marginalized populations.
>
> **Strategic direction 2:** promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes.
>
> **Strategic direction 3:** developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair.
>
> **Strategic direction 4:** developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

and submits to the Executive Board annual budget estimates, which then require only formal approval from WHA.[38] The Director-General or her/his representative can also, by agreement with members, have direct access to their various departments, especially to their health administrations and to national governmental and non-governmental health organisations.[39] Similarly, direct relations also can be established with international organisations whose activities come within the competence of the WHO.[40] As an additional responsibility, it is the Director-General who represents the WHO before the ICJ when an advisory opinion has been requested.[41]

The critical advantage for the Secretariat, which is essentially the administrative bureaucracy, is the fact that it is the only permanent organ of the WHO. It is, therefore, important to ensure an adequate degree of accountability to both the Executive Board and the WHA but the functional arrangements under the Constitution have proved to be inadequate in this regard. Part of the corporate strategy of the present Director-General has been to identify, for the first time, the core functions of the Secretariat in order to facilitate effective evaluation of its work. Until now the focus and direction of the Secretariat has been difficult to ascertain based as it was on pragmatic and diverse approaches to health. The future focus for the Secretariat, as determined by the Director-General, is to:

- articulate consistent, ethical and evidence-based **policy and advocacy** positions;
- managing **information**, assessing trends and comparing performance of health systems;
- setting the agenda for, and stimulating, **research and development**;
- catalysing change through **technical and policy support**, in ways that stimulate action and help to build sustainable national capacity in the health sector;

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[Executive Board, 105th session, January 2000, Official Records EB105/2, 'Towards a strategic agenda for the WHO Secretariat. Statement by the Director-General to the Executive Board at its 105th session, para.11.]

[38] When the constitutional amendment to Articles 34 & 55 has been sufficiently ratified the Director-General will no longer be under an obligation to prepare an annual budgetary report.

[39] Article 33 of the Constitution.
This was controversial at the time with some delegations wanting restricted access (Ukraine and Syria) and others unrestricted direct access (USA). [Proceedings and final acts of the International Health Conference, 1946, Official Records No.2, part III summary report of proceedings, p.22.]

[40] Article 33 of the Constitution.

[41] Ibid., Article 77.
The Director-General is under the obligation to ensure an objective case is presented. The desire to ensure a 'rounded submission' was taken too literally in the recent advisory opinion requested by the organisation concerned with the legality of nuclear weapons. The then Director-General was so concerned with representing the various opinions within the WHA that he did not make a clear, comprehensive and coherent presentation of the issues and concerns.

- negotiating and sustaining national and global **partnerships**;
- setting, validating, and pursuing the proper implementation of, **norms and standards**;
- stimulating the development and testing of new **technologies, tools and guidelines** for disease control, risk reduction, health care management and service delivery. [42]

While identification of such core functions may make formal accountability of the Secretariat easier to implement, it is difficult to see how the Secretariat of the WHO can perform these functions without some underlying value system around which the various functions can coalesce. The considered mission statement remains simply the attainment for all people of the highest possible level of health as set out in the Constitution of the WHO. This corporate strategy is simply a business tool being used to insert a measure of accountability into the functioning of the Secretariat but the substantive policy content remains strongly influenced by the Director-General.

**D. Regional Structure**

A distinctive feature of the structure of the WHO has been its incorporation of regional bodies, which has enabled the organisation to claim to be the most decentralised of all UN agencies. The degree and nature of this decentralisation, however, have been and remains controversial. These regional bodies were formed "to meet the special needs of such area[s]" implying a degree of autonomy at the regional level,[43] but they were also to carry out the decisions of the WHA and the Executive Board. The regional offices were to be established as an integral part of the WHO rather than establishing a federalised system. Certainly, at the

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[42] For a more detailed review of the future role of the Secretariat of the WHO see Official Records EB105/2 and
Executive Board, 105th session, January 2000, Official Records EB105/3, 'A corporate strategy for the WHO Secretariat. Report by the Director-General.'

[43] Article 44(b) of the Constitution.
The approach adopted was to require the consent "of a majority of the Members situated within such an area" for a region to be established and not the usual majority of the WHA. Perhaps it would have been more appropriate to require the unanimity of all states in an area. This may have avoided problems such as those that developed between Israel and the Eastern Mediterranean Regional. I refer to the dispute that led to the *Interpretation of the Agreement of 25 March 1951 between the WHO and Egypt*, Advisory Opinion [ICJ Reports 1980, pp.73].
For background details see: Siddiqi, J. (1994): World health and world politics: a study of the World Health Organization, Chapter 14.

International Health Conference, 1946, it was considered implicit that the regional organisation would be subject to the general authority of the WHA.[44]

The structure established that each regional office would be responsible to the Director-General[45] although the Executive Board (in agreement with the regional committee) would appoint the head of the regional office – the regional director.[46] Each regional committee is to include representatives of the relevant Member States and Associate Member States plus representatives of any area not otherwise represented (the nature and extent of the power of the latter group was to be decided by WHA and Member State concerned).[47]

This has resulted in the establishment of six regions each with a regional office and a regional committee.[48] The regional committee is comprised of representatives from the ministries of health of the region's Member States. The regional committee can meet as often as necessary. Generally, their regular meetings take place in September or October of each year to discuss policy, draft budget proposals and evaluate progress.[49] The policy issues for discussion are to be 'of an exclusively regional character,' and include supervision of the regional office, proposal of initiatives for the regional office, ensuring the necessary level of co-operation with other regional organisations as well as providing advice, via the Director-General, to the WHO on health matters.[50] Each regional committee has the power to recommend to the State parties concerned, separate budget supplements and this ensures a measure of financial autonomy.[51]

In theory, this was an exciting structural development for a newly formed international health organisation as it provided the infrastructure, particularly with the further inclusion of country representatives, to ensure

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[44] Concern at the International Health Conference about the formation of a federalised system led to the inclusion of Article 45 of the Constitution: "Each regional organization shall be an integral part of the Organization in accordance with this Constitution".
[Proceedings and final acts of the International Health Conference, 1946, Official Records No.2, part III summary report of proceedings p.24.]
[45] Article 51 of the Constitution.
[46] Ibid., Article 52.
[47] Ibid., Article 47.
[48] The six geographical areas and their corresponding regional offices are Southeast Asia – New Delhi, Eastern Mediterranean – Cairo, Western Pacific – Manila, Europe – Copenhagen, the Americas – Washington D.C. and Africa – Harare (temporary).
[49] Godlee, F. (1994c): 'The World Health Organisation: The regions - too much power, too little effect'. Vol. 309 British medical journal, pp.1566-1570, p.1566.
[50] Article 50 of the Constitution.

a strong grassroots connection. Practically, the decision to form such a decentralised organisation was, in the main, a political expediency. There were already two strong regional bodies in existence, which had to be incorporated into the WHO system, and refused to disband completely.[52] The Pan American Health Organisation, in particular, has sought to maintain a large measure of autonomy. Much of the tension and problems between the central and regional elements of the organisation are, at least in part, historically rooted. However, there have also been accusations of corruption,[53] regional politicisation[54] and inefficiency.[55] The consensus of most recent studies is that the structural division of the organisation between country office, regional office and headquarters is sound, but the daily functioning has been disappointingly limited.[56]

Although no such formulation is to be found in the Constitution of the WHO, country offices, with a WHO country representative, have been established in some developing countries. According to a recent study, the criteria for establishing such a body is based on a specific request by the government concerned and less specific socio-economic development and health needs.[57] "However, there is no systematic approach to this assessment, nor is there any formal mechanism for reassessing the size, role and functions of the WHOCOs that are in place."[58] Because the country representative is anticipated to work closely with the respective Ministry for Health, the structure has served to reinforce a medical model of health and has restricted the potential impact of such a representative. It is not yet clear how broader implementation of the current pilot studies being conducted under the co-ordination of UNDAF would impact on the role and

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[51] Ibid., Article 50 (f).
[52] The International Sanitary Bureau in Washington (now known as the Pan American Health Organisation) and the Conseil Sanitarie Maritime et Quarantinaire in Alexandria.
[53] Godlee (1994c), p.1567.
[54] Daes, E. & Daoudy, A.(1994): Decentralisation of organisations within the United Nations system. Part III. The World Health Organisation. Report of the Joint Inspection Unit. General Assembly Official Records. 48th session.
[55] COWIconsult, (1991).
[56] Reform measures are still being considered by the WHO.
[57] Lucas, A., Mogedal, S. Walt, G. *et al.* (1997): Cooperation for health development: the World Health Organization's support to programmes at country level. London : Governments of Australia, Canada, Italy, Norway, Sweden, and UK, p.21.
[58]Ibid., p.21.
This study advocated that an 'essential presence' mechanism be established to co-ordinate the interaction of the organisation with the Member State at country level. This would consist of one of four categories of physical presence and would be contractually based enabling regular assessment and review to occur (pp.183-189).

function of the country representative.[59] This new scheme utilises a separate framework under a resident co-ordinator, and so could impact on the line of accountability of the country representative and may even make their current role redundant. These country representatives could, however, serve a useful function as facilitator of local community participation. In this way, the voice of the grassroots would have access to the central institution and visa versa.[60]

**E. Position as Specialised Agency of the United Nations**

As a specialised agency of the United Nations, the WHO immediately had status and highlighted how important health and the right to health were considered to be to the prosperity of the world community. For the WHO to be an integral part of the UN system requires not only close working relations between the WHO and other relevant agencies but also, and more importantly, consensus as to the appropriate focus of the UN system on health and its attainment through compatible policy. The mechanics and legal obligations concerning the relationship of the United Nations and the WHO was established in the Agreement between the United Nations and the World Health Organisation, 1948.[61]

The UN Charter (Article 57) empowers the establishment of an agency to address health issues and along with other specialised agencies, is brought into relationship with the United Nations by virtue of agreements with ECOSOC as prescribed in Article 63 of the Charter. While the WHO is financially independent of the UN system, this does not make it autonomous. Through this treaty relationship there has developed a more dynamic and influential inter-active relationship than is initially apparent. The precise nature of this relationship is, however, difficult to define.

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[59] In 1997, as part of the UN Development Assistance Framework (UNDAF), a pilot study was launched in 18 countries that attempted to present a strategic programme framework under which the UN system could act with a common perspective, purpose and approach to aid a country's development. In June 1999, a second, revised pilot of 25 countries was launched that included a number of WHO Country Representatives. Since the WHO is now a member of the co-ordinating UN Development Group, it expects to have a different level of participation in future UNDAF exercises.
[Executive Board, 105th session, November 1999, Official Records EB105/15, 'Collaboration within the United Nations system and with other intergovernmental organizations. Report of the Secretariat.']

[60] To be effective in this role the number of country representatives would eventually have to be increased.

[61] The Agreement between the United Nations and the World Health Organisation was adopted by the First World Health Assembly 1948, Official Record No.13, WHA 1.102, p.59. For text see Basic documents, 1999, 42nd ed.

According to Calderwood, the nature of the relationship contemplated by the term 'specialised agency' gave rise to differing opinions at the outset.

> "For example, to some it meant an organization independently established and subsequently brought into relationship with the United Nations. To others it meant the establishment by the United Nations of a virtually autonomous but integral unit of the United Nations."[62]

Despite the subsequent formal agreement between the two institutions, these variations in interpretation as to their relationship seem to have alluded resolution. For example, the majority judgement in the *Legality of the Use by a State of Nuclear Weapons in Armed Conflict*, advisory opinion, held that to allow the WHO the competence to address the issue would be to ignore the 'principle of speciality'.[63]

> "As these provisions demonstrate, the Charter of the United Nations laid the basis of a "system" designed to organize international co-operation in a coherent fashion by bringing the United Nations, invested with powers of general scope, into relationship with various autonomous and complementary organizations, invested with sectorial powers. The exercise of these powers by the organizations belonging to the "United Nations system" is co-ordinated, notably, by the relationship agreements concluded between the United Nations and each of the specialized agencies."[64]

However, in his dissenting opinion, Judge Weeramantry strongly disagreed with this position believing instead that:

> "The family of United Nations organizations was not set up in a fretwork pattern of neatly dovetailing components, each with a precisely carved outline of its own. These organizations deal with human activities and human interrelationships, and it is of their very nature that they should have overlapping areas of concern. Their broad contours are of course defined, but different aspects of the self same question may well fall within the ambit of two or more organizations. The particularities of various international organizations were never meant to exclude areas of overlap, so long as these lay within the legitimate sphere of concern of the respective agencies involved. Specialized agencies with specialized interests can home in on specialized implications of some activity, which might otherwise pass unnoticed in other reactions to other aspects of the same problem. Complex problems have ramifications in many specialized directions to which the specialists alone are most competent to draw attention. Such a view contributes to the richness of the United Nations system. To expect otherwise would be contrary to the essence and rationale of a complex organization which straddles all facets of human activity."[65]

While some agreed with the opinion of Judge Weeramantry,[66] the majority decision of the ICJ effectively took "an unduly formalistic and narrow view"[67] of the competence and scope of activities appropriate for the WHO and thereby place the organisation in a much more restrictive relationship to the United Nations

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[62] Calderwood, H. (1975): 'The founding of a single international health organization.' Vol. 29 WHO chronicle, pp. 435-437, p.435.
[63] *Legality of the Use by a State of Nuclear Weapons in Armed Conflict*, advisory opinion, 1996 ICJ Reports, p.13.25.
[64] Ibid., p.13.26.
[65] Ibid., dissenting opinion, p.36.
[66] supported only by the dissenting opinions of Judge Shahabuddeen and Judge Korma.
[67] *Legality of the Use by a State of Nuclear Weapons in Armed Conflict*, advisory opinion, 1996 ICJ Reports, dissenting opinion Judge Korma, p.14.

than I believe is warranted. It would seem that the WHO is only to function independently within the confines of a literal interpretation of Article 2 of its Constitution. On other related health matters, it must defer to the 'United Nations system.' The organisations themselves have to develop an effective working relationship since the ICJ is expressly excluded from acting as final arbiter on "questions concerning the mutual relationships of the Organization and the United Nations or other specialized agencies."[68] With such public controversy, it is perhaps pertinent to refer back to the precise obligations as formalised in the treaty establishing this relationship.

The Agreement between the United Nations and the World Health Organisation recognises the WHO as "*the* specialized agency responsible for taking such action as may be appropriate under its Constitution for the accomplishment of the objectives set forth therein."[69] It is interesting to note that the United Nations considered that the WHO would be its sole organisation concerned with health. Under the Agreement, there is a policy of compulsory reciprocal representation established (Article II.1) whereby the UN representatives have the right to attend any formal meeting of the organisation but without the right to vote and visa versa. However, the level of active participation by UN representatives has been limited. Similarly, the WHO has an obligation to send representatives to the meetings of ECOSOC (Article II.2), but equally without the power to vote. The WHO, however, can only attend the General Assembly "for purposes of consultation on matters within the scope of its competence" (Article II.3), the interpretation of which remains predominantly with the General Assembly.

The organs of the WHO have an obligation to consider the recommendations of the United Nations as soon as practicable and to enter into a consultation process on request, with a duty to report back on any decision or action taken in relation to recommendations made. There is a clear treaty obligation to co-operate and co-ordinate activities and the dominant influence under the agreement is with the United Nations. This is not to suggest that the WHO is powerless to control its own policy agenda, for it remains a two way process. It does, however, have a mandatory legal duty to co-operate and render "such assistance for the maintenance or restoration of international peace and security as the Security Council may request" (Article VII).

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[68] Article X.2 of the Agreement between the United Nations and the World Health Organisation.
[69] Ibid., Article I, emphasis added.

The WHO has not always felt obliged to adopt UN recommendations. Membership of the organisation is one of the areas where the special relationship has been tested. In November 1977, the General Assembly adopted a resolution (A/RES/32/9E) that "[r]equests all specialized agencies and other organizations and conferences within the United Nations system to grant full membership to the United Nations Council of Namibia..." The WHO granted admission to Namibia[70] but only as an Associate Member and rejected, without any formal discussion, a later request by the representative of the UN Council for Namibia for full membership.[71] However, a different approach was taken with regard to the admission of the Democratic Republic of Germany. Admission was discussed for 5 consecutive years but refused because it was a political question on which the United Nations should first pronounce. Dr. Uctes (Guatemala) stated during one debate on the subject that

> "the WHO is essentially a technical body and as such, when problems with political implications or of a political nature arise, it must wait for the United Nations to study and analyse them, since it is inconceivable under any circumstances that one of the parts should be diametrically opposed to the whole and, in this case, the United Nations is the whole and the WHO is one of its parts, one of its specialised agencies.[72] By resolution WHA26.2, admission was finally granted but only after admission had already been granted by other UN bodies and specialised agencies without any controversy."[73]

On the whole, the WHO has taken a position that would seem to support the opinion of Dr. Uctes. It has maintained alignment with the rest of the UN system and has done so at the expense of its desire for universal membership although there has not been automatic adoption of UN policy.

While there is not a mandatory duty to conform to recommendations from the United Nations, the process does ensure that due consideration be given to such issues and has proved to be a major influence on WHO policy. Generally, the United Nations does have a broad supervisory role but the influence is persuasive rather than compulsory. The WHO has in the past been reluctant to warmly embrace all suggestions from the United Nations. The desire to maintain a much more separate agenda may undermine the effectiveness of the WHO to work within the UN system. It is true that any serious reform or dramatic policy change on the part of the WHO may not require the approval of the United Nations but would at least need its tacit

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[70] See 27th WHA, May 1974, Official Records No.217, WHA 27.3.
[71] See Executive Board, 57th session, 1976, Official Records No.231, Resolution EB57.R14, p.9.
For detailed discussion of the episode see: Osieke, E. (1980): 'Admission to membership in international organizations: the cost of Namibia'. Vol. 51 British yearbook of international law, pp.189-229.
[72] 25th World Health Assembly, May 1972, Official Records No. 202, 10th plenary meeting, pp. 204-205.

consent. This agreement between the two institutions could be re-negotiated with the consent of both parties.[74]

**F. Recent reforms within the United Nations system**

A recent review of policy co-ordination within the UN system, approved by the General Assembly, has instigated a series of reforms. These will necessarily impact on the WHO because of its specialised agency designation.

i) The **United Nations Development Group** has been created to facilitate a wide range of joint policy-making and decision-making of which health matters form a part. The WHO was not an original member of this group[75] but negotiated strongly to change this position and eventually became a member in July 1999.[76] The desire to be represented must stem partly from the WHO's level of involvement in the two pilot studies under the United Nations Development Assistance Framework (UNDAF)[77] but also from a need to maintain, or perhaps more realistically attain, a level of influence within the broader UN system.

ii) The United Nations **Department of Economic and Social Affairs** (DESA) now handles all socio-economic issues. The WHO is seeking to establish a closer working relationship with this department through the newly established Office for Inter-Agency Affairs. This relationship will be a limited and indirect influence via representation on the Administrative Committee on Co-ordination (ACC).[78]

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[73] 26th World Health Assembly, May 1973, Official Records No.209.
[74] For the WHO, this would require a 2/3 majority vote in the WHA. [Article 19 of the Constitution.]
[75] Original members were UNICEF, UNDP, WFP and UNFPA, this has been extended and now also includes UNIFEM, UNOPS, UNAIDS, United Nations Commission on Human Settlements, UNDCP, Department of Economic and Social Affairs, High Commissioner for Human Rights, IFAD, UNCTAD, Regional Commissions, and the Special Representative of the Secretary-General for Children in Armed Conflict. Others are members with observer status: United Nations International Partnership Trust Fund, Spokesman for the Secretary-General and Director, Office of the Deputy Secretary-General.
[76] See Executive Board, 105th session, December 1999, Official Records EB105/5, 'Poverty and health. Report by the Director-General.'
[77] UNDAF is under the guidance of the UN Development Group.
[78] The Office for Inter-Agency Affairs also services the ACC at which the WHO does have representation. The ACC was established in 1946 to serve as a standing committee of executive heads of United Nations organisations concerned with economic and social development. It is chaired by the Secretary-General and meets annually but there is no requirement for executive heads to attend or adhere to its decisions. As a result it tends to avoid controversial issues and has limited effect as a co-ordinating mechanism.
See Collinson, S. (1995): 'Global coordination of UN health activities: What are the formal mechanisms?' No.2 UN & health briefing note, (unpublished) pp.1-6, p.2.

iii) The **Office of Emergency Relief Co-ordinator** has also been established. The WHO does not participate in the work of this office but is involved in the Inter-Agency Standing Committee concerned with co-ordinating humanitarian affairs.[79] Keen to contribute as a full member rather than at this sub-ordinate level of consultation, the WHO has unsuccessfully been advocating the tightening of the procedures of the Inter-Agency Standing Committee in preference to the establishment of such new entities.[80]

iv) Further proposals have been made to establish a **special commission** at the ministerial level to examine the UN Charter and the treaties establishing specialised agencies.[81] Such a commission could have a major impact on the future development of the WHO and its relationship with the United Nations. So threatened was the WHO by this action that it considered instigating a legal review in consultation with other specialised agencies.[82] However, any decision to establish a special commission was postponed and is due to be considered by the UN General Assembly at a later date.[83] Until then, the WHO is seeking to use its influence on the Administrative Committee on Co-ordination to good effect.[84]

It is still too early to establish whether these changes within the UN system will improve internal communication and co-ordination. It is clear that such reforms impact strongly on the functioning of the WHO. They reiterate the intimate relationship between the two but with the power balance ultimately vested with the United Nations. The action taken by the WHO to maximise its influence suggests it acknowledges the situation. This marks an important shift in approach for the organisation There is now recognition that the WHO needs to be as a primary player within the United Nations rather than maintain its past isolationist policy. The WHO cannot expect to have a dominant role in all issues of health within the United Nations. It needs to recognise the importance of strategically prioritising to maximise its influence effectively. This is difficult to do without first developing an underpinning focus for the organisation. Adoption of the right to health to provide this direction would enable identification of the

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[79] Executive Board, 103rd session, November 1998, Official Records EB103/29, 'UN system reform. Report by the Secretariat: submitted to the Executive Board for information.'
[80] Executive Board, 101st session, November 1997,Official Records EB101/17, 'Collaboration with the UN system and with other intergovernmental organizations: General matters. Report by the Director-General.'
[81] Based on the outline proposed in the Secretary-Generals reform report (A/51/950, para.89).
[82] Official Records EB101/17.
[83] As of July 2001 no final decision had been made.
[84] Official Records EB103/29.

most important areas of focus for the WHO within the United Nations as compared to others where reduced involvement may be more appropriate.

**G. Could such a system be utilised to promote the right to health?**

Structurally, the WHO is similar to most centralised institutions in that it attempts to maintain an effective operation through the separation of powers. Unfortunately, due to financial constraints, the Secretariat is the only organ in permanent existence. This tends to encourage a bureaucratic approach to health and weakens the available means of ensuring accountability. Adoption of a corporate strategy may improve efficiency and the effectiveness of the Secretariat but the policy direction of the WHO remains too dependent on the personality and agenda of the Director-General. Because of this, adoption of an integrated human rights approach to health would be very dependent on gaining the support of the Director-General. The only other option would be if an important donor state decided to provide the necessary financial support and applied pressure via the WHA and the Executive Board to establish such an approach. The development of an isolated programme would be less likely to successfully implement the right to health throughout the organisation. Alternatively, overt pressure would need to be applied from within the UN system by, for example, the Committee for Economic, Social and Cultural Rights. The adoption of an advisory council of experts (preferably not just medical experts) should be reconsidered to regain balance within the WHO by separating responsibility for substantive content from implementation. The notion of an advisory council of experts was originally considered at the International Health Conference in 1946, when the Constitution of the WHO was being drafted, and has been mooted on various occasions since.[85]

The regional structure adopted by the WHO provides the organisation with an important strategic advantage should it seek to promote the right to health. This decentralised approach enables the organisation to have direct access to grassroots organisations thereby allowing a greater level of interaction and communication. Dialogue between the various levels is essential. For example, to enable the locality to identify with and protect the right to health; the state concerned to promote and protect the right; and to provide the centralised body with correlated data to determine practical, effective and pertinent normative standards concerned with giving effect to the right to health. Recent reform within the United Nations

sought to emulate the decentralised structure of the WHO. Unfortunately, the five UN Regional Commissions refer to different geographical areas, thereby limiting the effective co-ordination of work. However, the establishment of this broader initiative would enhance co-operation and co-ordination between the various institutions at a regional level, thereby expanding the WHO regional offices' ability to act as advocates for the right to health.

As various studies have already indicated effective advocacy can only occur following some internal reform to improve efficiency, accountability and ensure consistency of approach. A recommendation has been made to cease the appointment of politicians to the regional committees and instead use health professionals.[86] Clearly, the aim here was to minimise the politicisation of the posts. While this is positive, I would advocate utilising a variety of different types of health professionals. Certainly, some background in health is important but if the regional offices are to become a conduit for dialogue then it may be appropriate to have delegates with social policy and development skills, knowledge of human rights and knowledge of local NGOs as well. The need to develop a structured reporting system to the Executive Board has also been highlighted.[87] Although need for administrative reform limits the potential of the regional office to function as an advocate for the right to health, it does not negate the possibility. In my opinion, the regional offices' essential roles to promote the right to health should be:

a) To act as **advocate** and **educator** on the concept and content of the right to health in its relations with other regional bodies, State party governments within the region, non-government agencies in the health field and local communities. Also, to act as the co-ordinator and facilitator by which individuals and communities can seek to use legal and political mechanisms to protect their right to health.

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[85] See chapter 8 for a more detailed explanation of my proposal.
[86] COWIconsult, (1991).
[87] Ibid.
I disagree with several of the other major changes considered in the report:
1) Regional committees should only avoid becoming embroiled in personal politics. Advocacy of the right to health or even implementation of the Health-for-All programme contain political elements that need to be addressed. Limiting regional committees to technical and operational issues would seriously limit the potential of the regional offices.
2) Reducing the frequency of committee meetings from two a year to one every other year may save on administrative costs but would seriously reduce the ability of the regional office to maintain effective communication and to react to developments.
3) The regional directors' power should be curtailed, with devolution of authority over country programmes to country representatives.

b) To **Monitor and evaluate policy** so as to ensure conformity with the right to health. This will require the development or adaptation of indicators to reflect local needs as well as the collecting and processing of the statistical data.

c) To **promote public participation** with the regional office providing the essential link between headquarters and the grassroots. This would require a greater use of modern technology to disseminate information and correlate feedback.

d) To become an **Internal communication conduit** through which the headquarters can communicate and support the country officers by providing information, expertise and technological support, as well as correlating data, writing critical reports and evaluating policy and its impact. The effective flow of information between the various levels is essential if the right to health is to have a practical effect.

At the country level, the WHO's country representatives have had varying levels of success. If the current pilot studies are utilised more generally, then the country representative will have broader access to information and policy decisions making it easier for the WHO to establish joint projects and locally access a broader range of expertise. If the pilot approaches are adopted, they will also provide an exciting environment in which the country representative can act as advocate for the right to health. It would be essential for the local representatives to have a clear understanding of the concept of the right to health because their role would be to facilitate adoption of the right to health at the local level.

In addition, the fact that the country representatives have such a strong connection to the Ministry for Health could be used to educate and assist the Ministry and the broader government to fulfil its obligations in relation to the right to health. To establish effective dialogue and encourage the use of specific indicators and human rights based policy, country offices should also seek to broaden collaboration by forming connections to local NGOs, boards of ethics and health facilities. Because the country officer's role would be pivotal to the WHO's ability to effect the right to health, it will be essential that the representative have

the necessary support at the regional and central level.[88] To achieve this would likely require the country representative to have greater participation in the policy process and determination within the WHO, to more generally develop a team ethos.

[88] The notion of extending the role of the liaison office to support the county offices by functioning as a 'help desk' to direct inquiries from different levels of the organisation to the appropriate source is a useful start but is not sufficient effective support. The idea of a help desk along with a database on developments at regional and country levels are currently being put into practice.
[Executive Board, 105th session, December 1999, Official Records EB105/7, 'Working in and with countries. Report by the Director-General'.]
These resources could be broadened to be a useful tool for local communities and individuals as well as country offices and could eventually be extended to facilitate dialogue and participation with the grassroots.

## 7.
## The legal powers of the World Health Organisation

Until recently, little attention has been given to the legal powers. The decision to draft a Framework Convention on Tobacco Control has certainly raised the profile of these potential powers. The question therefore arises as to whether the WHO can more effectively utilise the legal powers expressly provided for in its Constitution to forward its role as director and advocate of international health. Furthermore, is it also possible that these legal powers could, indeed, provide the appropriate and necessary tools to enable the WHO to develop a pivotal role in the future development of the right to health? To answer these questions, a careful review of the legal powers of the WHO is in order.

The establishment of specialised agencies such as the WHO marked a significant development in the relations of nation states. States transferred a measure of sovereignty to an international organisation on the understanding that this would produce an effective channel for co-operation within a specific field of focus.[1] The degree of power delegated, however, remained confined by the very concept of state sovereignty itself.[2] But, it was considered necessary for such international organisations to be provided with the means to enact and amend predominantly technical rules within their field of competence so as to ensure that these rules would have validity for all members.

Articles 19 to 23, of the Constitution of the WHO enable the WHA, to adopt draft conventions or agreements, regulations and recommendations within certain specified parameters.[3] The contractual nature

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[1] Head, J. (1994): ' Supranational law: how the move toward multilateral solutions is changing the character of "International" law'. Vol.42 University of Kansas law review , pp.605-666 at p.606 and Yemin, E. (1969): Legislative powers in the United Nations specialized agencies at p.212.

[2] However, as Head points out:

> "(N)ew players and new rules have made obsolete the concept of an "international law" concerned solely or primarily with nation-states abiding by rules emanating from their own free will." [Head (1994), p.635.]

[3] The draft proposal by the Technical Preparatory Committee was weaker in that it only mentioned promotion of conventions, regulations and agreements [Official Records No.1, 1946, Annex 23, p.70]. It may be that recommendations were considered as performing a similar function to World Health Assembly resolutions.
The American reservation also sought to restrict the powers of the WHO:
"[T]he Congress does so with the understanding that nothing in the Constitution of the World Health Organization in any manner commits the United States to enact any specific legislative program regarding any matters referred to in said Constitution."
[United States Code, title 22, Government Record Office, Washington DC, pp.4477-8] :
Also see Legal Note, ' The US Reservation to the Constitution of the WHO', American Journal of International Law, Vol.44 (1950), p122.

of the Constitution being such, these powers can only be utilised in relation to Member States unless a non-member state specifically accepts and adopts the legislation.[4]

**A. International treaties, conventions and agreements**

Article 19 of the Constitution provides the authority for the WHO to adopt conventions or agreements with respect to any matter 'within the competence of the Organization'.[5] By so doing, it provides the WHO with broad authority to exercise this power, as it deems appropriate to perform its wide-ranging constitutional objectives and functions within the health sphere.[6] However, to date, despite being traditionally "the only and sadly overworked instrument of the international community"[7] this power has not been directly utilised by the WHO.[8] A two-third majority vote of the WHA is required for the adoption of any such convention or agreement which must then be ratified by all Member States in accordance with each Member State's own constitutional processes but within a time limit of eighteen months.[9] Once the treaty has been

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But, unfortunately, this American reservation has been the focus of little significant discussion in contrast to the upset surrounding the withdrawal reservation made by the United States at the same time. It remains unclear whether this reservation was accepted as such or considered a mere declaration. As a reservation, it would only impact on the United States' position in relation to regulations where the 'contracting out' process has been adopted (see later in chapter) as treaties and recommendations still require formal acceptance by each State party.

[4] An exceptions to this, however, is if states comply with the non-binding instrument in such a way as to create customary international law. This is defined in the Statute of the ICJ as "international custom, as evidence of general practice accepted as law".
[Article 38b; for further details see generally: Akehurst, (1974-5): 'The hierarchy of the sources of international law.' Vol. 47 British yearbook of international law, pp.273; D'Amato, A. (1971): The concept of custom in international law; and the *North Sea Continental Shelf* case, 1969 ICJ Reports.]

[5] See World Health Organization, (1999) (42nd ed.): Basic documents.

[6] Interestingly, there was a recent proposal to delegate power to regional committees to enable the adoption of international conventions on matters of a strictly regional nature. Delegation of authority from the WHA to regional committees was considered the most appropriate course to avoid delays. Legally such delegation of power would necessarily require constitutional amendment. The only alternative approach would be for the regional committee concerned to seek an authorisation from the WHA on a case-by-case basis.
[See Executive Board, 105th session, November 1999, Official Records EB105/29, 'Regional committees and regional conventions.']
No formal resolution was adopted and so the future of this particular proposal is uncertain.

[7] Skubiszewski, K. (1965-1966): 'Enactment of law by international organizations'. Vol. 41 British yearbook of international law , pp. 198-274 at p.274.

[8] The WHO has, however, been actively involved with some important treaties related to health such as the Narcotics Convention, 1961, and the Convention on Psychotropic Substances, 1976, but it has not used its constitutional powers to instigate the drafting of relevant treaties.

[9] It remains unclear from the constitutive document where the real treaty-making power of the organisation lies. Clearly, the WHA is not a suitable body to negotiate and draw up treaties. The Secretariat, as the only permanent organ, is the more appropriate body. In the case of the WHO, the issue of 'democratic control' of delegated power is resolved by the constitutional requirement that the WHA alone can approve the treaty once it has been drawn up.

accepted by the Member State, the Member State must also notify the Director-General of the action taken and establish a domestic system that will enable the Member State to fulfil its obligation to subsequently report annually on implementation of the treaty.[10]

The fact that to be effective, treaties must normally be ratified through domestic constitutional procedures or be backed by some form of legislative action by the state can be a serious limitation on their effectiveness as a harmonisation tool. These processes can be slow, erratic and may even be hijacked for unrelated political ends. Therefore, adopting the process of treaty making presents an inherent risk of delay, non-uniformity of adoption or rejection by states.[11] The practice of reservations to treaties can also cause further confusion and inconsistencies.[12] However, treaty obligations remain the clearest examples of international law and place explicit, binding legal obligations on states adopting them.

These problems are obvious reasons that may deter organisations from embarking on the treaty-making process and, certainly, it will not always be the most appropriate mechanism to achieve all the health aims and objectives of the WHO. This appears to be the opinion of Fluss and Gutteridge:

> Thus, the sheer difficulty inherent in the treaty-making process when dealing with a large number of States (as of September 1993 WHO had 187 Member States), the scientific and technical considerations involved in the field of health and medicine, the advantages resulting from reciprocal acceptance of scientific and technical standards drawn up by a body which enjoys the confidence of States, and the general pattern of international health policy-making process since the establishment of the first international organizations in the health field, have resulted in WHO turning away from the traditional treaty-making process towards more direct and simplified procedures in those areas in which it is competent and where action is necessary to lay down international standards and norms and to cooperate with governments in coordinating their actions.[13]

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For a more detailed discussion of this issue see Detter, T. (1962): 'The organs of international organizations exercising their treaty-making power'. Vol. 38 British yearbook of international law, pp. 421-444.

[10] As specified in Article 20. Even Member States that have not accepted the treaty have a constitutional obligation to notify the Director-General of the reasons for their non-acceptance.
[See World Health Organisation (1999): Basic documents.]

[11] It must not be forgotten, however, that treaties, conventions and agreements in international law can be extremely influential despite failure to obtain universal ratification. Here, I am thinking particularly of some human rights treaties and treaties concerned with environmental issues that have had a major impact on international policy despite the failure of some influential states to ratify them.

[12] For a more detailed analysis of the problems associated with treaty reservations see: the *Anglo-French Continental Shelf* case, 54 ILR 6 and the *Genocide Convention (reservations)* case, 1951 ICJ Reports 15. It is important to note, however, that Article 19 makes no specific reference to reservations in relation to treaties, unlike Article 22 concerning regulations. The effect of this omission is unclear and would therefore need to be clarified in each treaty drafted.

An internal review of WHO's strategic policy would also seem to support this conclusion.[14] This is an unfortunate conclusion when comparison is made with the impact that such organisations as the ILO have achieved utilising very similar powers.[15]

Instead of using its power to draft treaties, the WHO has preferred instead to adopt declarations. A declaration can be a useful tool to articulate the importance of the WHO's underlying strategies to the international community generally, but it remains a political rather than a legally binding document.[16] It is possible to argue that declarations can be the first step in a process towards drafting a treaty in the same manner as the Universal Declaration of Human Rights, 1948, was a precursor to the subsequent ICCPR and the ICESCR, 1966. The Alma-Ata Declaration on Health-for-All was suggestive of this approach when adopted in 1978. The strategies and policies contained in the Health-for-All approach have since been well documented and refined and have received the endorsement of the UN General Assembly, as well as the WHA, on numerous occasions. So it was surprising that the WHO chose, in celebration of its

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[13] Fluss, S. and Gutteridge, F. (1993): 'World Health Organization' in Medical law, suppl.1, Blanpain, R. (ed.), p.36-WHO (draft copy with author).

[14] EB97/9 expressed the opinion in relation to conventions that: "The practical relevance of the authority to adopt conventions might be questioned . . . By the time a convention enters into force it may have lost its relevance."
[[Executive Board, 97th session, November 1995, Official Records EB97/1996/REC/1, 'Review of the Constitution of the World Health Organization by the Director-General' at p.4].
Similarly, A49/4 Implementation of Resolutions, VI. Tobacco or Health [(b)7, p.18] states that :

> "Treaties, conventions , protocols, covenant or pacts are essentially international agreements in whatever form, between States, or between States and international organizations. Becoming a party to such instruments creates an obligation for the States concerned to develop national legislation in accordance with their international commitments. Comprehensive conventions, by their detailed nature, will stimulate specific and detailed national legislation. The negotiation, signing and ratification of treaties are usually slow, and delays of more than 10 years may occur before they enter into force. Perhaps the most significant drawbacks is the possible absence of global political support for binding international rules, which may be considered by many as interference with the domestic affairs of individual States. Since only States that become a party to an international convention are bound by it, there may be considerable difficulty in ensuring international support for a complex and detailed global tobacco control convention."

[49th World Health Assembly, February 1996, Official Records WHA49/1996/REC/1, 'Implementation of resolutions. Report by the Director-General'].

[15] For a detailed comparison of the legislative approaches of the UNEP, IMO and ILO see Taylor, A. (1992): 'Making the World Health Organisation work: a legal framework for universal access to the conditions of health'. Vol.XVIII No.4 American journal of law and medicine, pp.301-346.
UNEP uses treaties in conjunction with domestic legislation. The IMO also uses the technique of broad international agreements coupled with nationally designed implementation measures to secure international agreement on environmental matters. (pp.332-335)
The result is that organisations such as the ILO, IMO and UNEP have succeeded "in establishing themselves as centers for policy debate and international codification, promoting and guiding governmental action." (p.341)

50th anniversary, not to formalise this Declaration into a binding treaty. Instead, it reformulated the material into another non-binding declaration, the World Health Declaration.[17] The drafting of a treaty would have been an obvious choice, assuming the WHO were looking to use its powers to formulate binding instruments. A health treaty would have provided an important framework document from which to consolidate international health. Oddly, the decision was instead made, using powers that are untested, to tackle a controversial and complicated issue such as tobacco, which has powerful and antagonistic lobby groups.

**B. Framework Convention – Protocol approach**

An alternative to avoid some of the risks associated with the traditional treaty system is to use the currently popular 'framework convention-protocol' approach. This is the approach the WHO has adopted regarding tobacco control.[18] The theory holds that the framework convention-protocol approach does not seek to resolve all the substantive issues in a single document. Instead, it divides the negotiation of separate issues into separate agreements. However, the need to negotiate several agreements and sub-agreements simultaneously means that it is also a slow and complex process. Nevertheless, it is felt that by breaking the issues down into manageable segments it is possible to make steady progress with a high measure of consensus.[19] The first stage would be for states to adopt a framework convention that establishes co-

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[16] Of course, it is possible that such a Declaration would inspire sufficient international practice with the necessary *opinio juris* to be accepted as customary international law. It is extremely unlikely that the whole document would be transformed in this manner and it would be a slow and unpredictable process.

[17] Resolution WHA51.7 adopted the World Health Declaration under Article 23. See chapter 4 for further details on the content of the. World Health Declaration.
[51st World Health Assembly, May 1998, Official Records, 'Health for all for the twenty first century'].

[18] The **general objectives** of the Framework Convention on Tobacco Control to-date are considered to be:
1) To protect children and adolescents from exposure to and use of tobacco products and their promotion;
2) Prevention and treating tobacco dependence;
3) Promoting smoke-free environments;
4) Promoting healthy tobacco-free economies, especially stopping smuggling;
5) Strengthening women's leadership role in tobacco control;
6) Enhancing the capacity of all Member States in tobacco control and improving knowledge and exchange of information at national and international levels;
7) Protecting vulnerable communities, including indigenous peoples.

With specific objectives in relation to:
Prices, smuggling, tax-free tobacco products, advertising/sponsorships, Internet advertising/trade, testing methods, package design/labeling, information sharing and agricultural diversification.
[As stated on p.2 of 'Tobacco Free Initiative; Introduction to Framework Convention on Tobacco Control' at http://www.who.org/toh/fctc/fctcintro.htm, Nov. 1999.]

[19] This model was successfully adopted by the ECHR. It has so far proved to be a successful tool to tackle substantial environmental issues and was strongly advocated by A. Taylor in her article [(1996): 'An international regulatory strategy for global tobacco control.' Vol.21 Yale journal of international law, pp.257-304].

operation to achieve broadly stated goals, then later there would be the option for parties to the convention to conclude separate, additional protocols containing specific measures designed to implement specific segments of the established goals.

The Director-General and the Executive Board felt that the 'framework convention-protocol' approach was likely to be more politically acceptable than any other binding approach to tobacco control. Although 'technically binding,' it was also considered that framework conventions "actually fall somewhere between non-binding resolutions and treaty law since they contain no explicit obligations".[20] The framework convention-protocol approach also is regarded as having the potential to initiate "a continuous and dynamic process of law-making." Despite the Director-General's assertion that this approach has a less legally binding effect in international law, I would contend that in reality there is little to differentiate this approach from that of traditional treaty-making. The establishment of a treaty, regardless of whether it is the base for action or not, remains the same, but with the protocol system this initial treaty becomes just one of a series of treaties. Still, this could be the best approach for future development of the right to health.

**C. Regulations**

No definition of the term 'regulation' is provided in the WHO's Constitution and the only consensus among academics is that Articles 21 and 22 enable the WHA to adopt provisions with legal status 'intermediate between binding rules and recommendations'.[21] Regulations must be considered closer to treaties than recommendations in the sense that they create legal rights and duties, which do impact on states. But the power vested in the organisation is different in the sense that it is not contractual but rather

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[20] Official Records WHA49/1996/REC/1, A49/4.
A similar approach has been used by UNEP to foster broad consensus among nations for measures to guard against depletion of the ozone layer.
[Vienna Convention for the Protection of the Ozone Layer, 22 March 1985. Montreal Protocol on Substances that Deplete the Ozone Layer, 16 September 1987. Amendment to the Montreal Protocol on Substances that Deplete the Ozone Layer, 29 June 1990].

[21] As defined by Yemin (1969), p.204.
Reiterated by Codding, G. (1965): 'Contributions of the World Health Organization and the International Civil Aviation Organization to the development of international law'. Proceedings of the American society of international law, pp.147-153, p.148; and
Del Ponte, K. (1982): 'Formulating customary international law: an examination of the WHO international code of marketing of breastmilk substitutes'. Vol.5 (2) Boston College international & comparative law review, pp.377-403 at p.389.

is legislative, or possibly quasi-legislative, in nature.[22] Importantly, a WHO report defined regulations as constituting "a new departure in international law by laying obligations on states without signature and ratification of a formal treaty".[23] However, according to a draft report by the Director-General, each Member State is 'bound' by a regulation but has discretion to use the means it considers necessary, at a domestic level, to give effect to the measure.[24]

The WHO, therefore, seems to have the power to require a particular result but not the means by which this is to be achieved. This approach is similar to that developed by the European Community in relation to its interpretation of regulations under the Treaty of Rome.[25] The interpretation constructed was the result of contentious case law and reflects the position of the ECJ; established to interpret and adjudicate such issues. The Constitution of the WHO, however, failed to provide any mechanism by which the organisation could monitor and ensure full compliance of its members to its legislation. It is possible, however, to incorporate an appropriate mechanism within the terms of the regulation itself.[26] It is also possible to establish a dispute-settlement process within the terms of the regulations. The International Sanitary Regulation allows for first reference of a dispute to the Director-General, and if not so settled, then it is referred to an 'appropriate committee' or 'other organ' of the WHO for settlement.[27] Other options such as those developed by the IMO and the ICAO could also be adopted to ensure compliance

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[22] Yemin argues that there are three elements necessary to identify legislation. It must be unilateral in form, have full legal force for non-reflecting Member States and be general in character. Within specific constitutional limits the power to formulate regulations can be classified as such. Alternatively, this power may be only 'quasi-legislative' in nature because although the necessary elements for legislative power can be identified there are too many strict limitations for it to be considered as such.
[Yemin (1969), p.204].

[23] WHO, (1958): The first ten years of the World Health Organization.
Article 22 specifically states that "[r]egulations adopted pursuant to Article 21 shall come into force for all Members after due notice has been given of their adoption by the Health Assembly..."
[ World Health Organisation (1999): Basic documents]

[24] To be found in the report by the Director-General on the draft international code of marketing of breast milk substitutes to the Thirty-Fourth World Health Assembly.
[34th World Health Assembly, May 1981, Official Records A34/8, Annex 4 at p.3].

[25] The significant difference in effect, however, is due to the fact that each party to the Treaty of Rome had incorporated the treaty into its own domestic system so that European regulations would not only be directly applicable but would have direct effect and be enforceable within the domestic legal system. For more information in this area see: Steiner, J. (1990): Textbook on EEC law or Weatherill, S. & Beaumont, D. (1993): EC law.

[26] It would probably be more appropriate to establish a simpler mechanism such as a reporting system, however, if a substantial network of obligations were established other dispute resolution mechanisms might need to be considered.

[27] According to Fluss, the vast majority of disputes have been settled by reference to the Director-General. [Fluss, S. (1995): 'The development of national health legislation in Europe: the contribution of international organizations'. Vol.2 European journal of health law, pp.193-237 at p.213.]

with regulations. For example, to meet the increasing volume and complexity of international maritime disputes, the IMO produced a set of appropriate rules for maritime arbitration and the administration of arbitration cases is entrusted to the International Maritime Arbitration Organisation. Whereas, to ensure compliance with the international standards and regulations adopted by the ICAO, the Assembly of ICAO decided to review in detail the complete work programme of the organisation in the technical, economic, legal and technical assistance fields and give guidance to the future work of ICAO on a regular basis.

The precise relationship of a treaty to a regulation in international law remains unclear. To date, the WHO has only formulated two sets of regulations: Nomenclature Regulations[28] and the International Sanitary Regulations.[29] The Nomenclature Regulations have no provision establishing the relationship of regulations to previous conventions on the same subject. Instead the assumption seems to have been made that these previous conventions should be considered to have lapsed 'as a result of desuetude'.[30] Article 105 of the International Sanitary Regulations, however, states that the regulations shall "replace, as between the States bound by these Regulations and as between these states and the Organization, the provisions" of the previous conventions. Vignes[31] suggested that the use of the word 'replace' rather than 'abrogate' may permit continued application of those provisions of the earlier conventions and agreements, which relate to provisions not addressed in the Regulations. Yemin,[32] however, concluded that the earlier conventions and agreement could be considered to have been implicitly terminated by the entry into force of a later international instrument governing the same matter.[33] According to the Vienna Convention on the

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[28] Incorporated the International list of diseases and causes of death as well as their statistical classification.
For detailed history of Nomenclature Regulations see Yemin (1969), p.184-5.
Initially adopted in 1948 [First World Health Assembly, 1948, Official Records No.13, p.349] and simplified in 1967 [20th World Health Assembly, 1967, Official Records No.160, p.10].
This later version omitted certain detailed rules concerning classification and other requirements that had been included in the 1948 version. These rules remained but took the form of recommendations promulgated by the Assembly under Article 23 of the Convention. "As regards the legal force of these recommendations, which appears under the Nomenclature Regulations, 1967, to be somewhat greater than that imparted by Article 23 of the Constitution to ordinary recommendations . . ."
[20th World Health Assembly, 1967, Official Records No. 160, WHA20.19, p.11].
[29] Adopted in 1951 (Fifth World Health Assembly, 1952, Official Records No. 35, WHA4.75, p.50) to replace 12 and part of the 13th, International Sanitary Conventions and similar agreements concluded between 1903-1944. They were concerned with the containing of the international spread of such diseases as cholera, the plague and yellow fever but without unduly hindering international trade and travel.
[30] Yemin (1969), p.193.
[31] C.H. Vignes, (1965) 'Le reglement sanitaire international', AFDI, pp.656-657.
[32] Yemin (1969), p.193.
[33] Admittedly, both these writers were considering these legal issues in the period prior to the entry into force of The Vienna Convention on the Law of Treaties, 1969.

Law of Treaties, termination or suspension of operation of a treaty can be implied but only with the conclusion of a later treaty.[34] It is debatable whether a regulation can be considered a type of treaty under its definition.[35] It is obvious that the relationship between treaty and regulation will need to be clarified if regulations are to become an important and effective tool to facilitate international health policy. There would seem to have been envisaged, on a literal interpretation of Articles 19-23, a clear hierarchy of legal powers to enable the WHO to achieve its objectives. Treaties remain at the highest level because they, being the traditional tool of international law, enable the organisation to establish clear, legally binding commitments by states. Regulations were developed to ensure that there was a quicker, more flexible means of addressing and responding to what were considered, at the time, to be particularly pertinent international health issues. It would be inconsistent, given the conservative approach to state sovereignty, to assume that such a tool had been developed to circumvent the treaty system completely.

The process of adoption of regulations, as specified in Article 22, is by a simple majority of the WHA.[36] All members are bound by the effect of the regulation unless the Director-General within a designated time-frame receives notification of rejection or reservations.[37] This 'contracting out' process did cause concern because there was fear that this approach could lead to states being bound by oversight.[38] The drafting committee suggested, however, that this was unlikely because the WHO was to be structured so as to have direct access to the health administration of each Member State enabling notification to efficiently

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[34] Under Article 59.1(a) and (b) of the Vienna Convention on the Law of Treaties.

[35] The Vienna Convention on the Law of Treaties, 1969, defines a treaty in Article 2.1(a) as:

> "an international agreement concluded between States in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation;"

and in theory such a definition could include these particular regulations. However, Article 9.2 requires that:

> "adoption of the text of a treaty at an international conference takes place by the vote of two-thirds of the States present and voting, unless by the same majority they shall decide to apply a different rule."

WHO regulations only require a majority vote under Article 60(b) as they are not included in the matters enumerated in Article 60(a) of the Constitution and have not been considered by the WHA as important enough to warrant transfer to the procedure outlined in Article 60(a). Also, the separate treatment of the two powers under Articles 19-20 and 21-22 of the Constitution suggests that the two issues cannot be assimilated.

[36] This will only enter into force after due notice is given to members (Article 22). For the Nomenclature Regulations and International Sanitary Regulations, approximately 16 months were allowed between date of adoption and entry into force whereas for amendments to these regulations time allowed varied from sixty days for minor amendments to nineteen months.
[Yemin (1969), p.192].

[37] In a similar manner to treaties, these regulations are then published in the UNTS.

reach the government agency most concerned.[39] States were further placated by the limited uses of such power being made available to the WHA under Article 21, which states:

The Health Assembly shall have authority to adopt regulations concerning:

(a) Sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;

(b) Nomenclatures with respect to diseases, causes of death and public health practices;

(c) Standards with respect to diagnostic procedures for international use;

(d) Standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;

(e) Advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.[40]

The list restricts the use of regulations to technical issues concerning standardisation and data collection and probably is the reason why to date there have only been the two sets of regulations.[41] The possible adoption of additional regulations has been discussed at various times in connection with such varied topics as: international maritime venereal disease control; the control of malaria; the International Pharmacopoeia and pharmacopoeial formulas for potent drugs; quality control of drugs; biological standardisation; and the use of breast-milk substitutes for infant feeding. However, because the governing bodies have not been prepared to extend the coverage of Article 21, these matters have eventually been

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[38] As expressed by the Belgium delegation at the International Health Conference Proceedings and Final Acts, 1946, Official Records No.2, p.20.

[39] It was also considered to be a preferable process to that proposed by the Russian delegation whereby a two-third majority vote in the WHA would bind all parties.
[International Health Conference Proceedings and Final Acts, plenary meeting, 1946, Official Records, No.2, p.21.]

[40] The list of items to be the subject of regulations was extended beyond the original report of the Technical Preparatory Committee, but the Conference refused to approve the recommendation of the Administration and Finance Committee that it should also extend to the prevention of the importation by members of any of the foregoing products which did not conform to standards adopted by the WHA. This was rejected because many Latin American and Soviet States considered that this dealt with issues concerning commercial policy rather than health and as such did not fall under the jurisdiction of the organisation. [International Health Conference Proceedings and Final Acts, 1946, Official Records No.2, p.21].

[41] These regulations are now referred to as the International Health Regulations and are currently in the process of being updated.
See: 48th World Health Assembly, May 1995, Official Records WHA48.7; 49th World Health Assembly, May 1996, Official Records A49/6 Add 1; and 52nd World Health Assembly, April 1999, Official Records A52/9.

dealt with by the adoption of recommendations or technical standards.[42] Such restrictions would not prevent regulations, as described above, from being used to implement aspects of the proposed Framework Convention on Tobacco Control under Article 21(d) and (e).[43] But if the strategic use of regulations were to be adopted more widely by the WHO some constitutional amendment would be necessary.

The Constitution of the WHO has been the subject of a major review within the organisation instigated in 1995 by WHA 48.14.[44] The Director-General's report to the Executive Board in November 1995 did suggest that "[c]onsidering the importance of problems concerning ethics, transplants, genetics, etc., the Executive Board might wish to consider extending the scope of Article 21".[45] A proposal recently made to the WHA advocated the addition of a sixth specific area on which the Assembly would have authority to adopt regulations and a clause permitting regulations to be adopted on any subject. The new area would be:

> Article 21 (a) (vi) standards with respect to transplantation of tissues and genetic engineering, including cloning.

With a new section (b) which would state:

> The Health Assembly shall have authority to adopt regulations concerning any other health-related matter falling within the functions of the Organization as set forth in Article 2.[46]

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[42] Fluss, S. and Gutteridge, F. (1993): 'World Health Organization' in Medical law, suppl.1, Blanpain, R. (ed.). Netherlands : Kluwer, p.21-WHO (draft copy with author).
These bodies were not even prepared to resolve an apparent inconsistency in the Constitution concerning the above provisions and those of Article 2(u); the latter includes food together with biological, pharmaceutical, and similar products as items in respect of which international standards may be developed, established, and promoted. The issue became particularly pertinent in connection with the development of an International Code of Marketing of Breast-Milk Substitutes and was resolved by the formation of the Code merely as a recommendation.

[43] A49/4 concerning the implementation of 'tobacco or health' was concerned at the limited range of subjects available for the implementation of regulations under Article 21. The EB concluded that an international instrument for tobacco control would be most effective if it were broader in scope rather than only addressing issues of "standards for the safety, purity, potency, advertising and labeling" of tobacco products "moving in international commerce." Moreover, some members of the EB observed that international regulations on tobacco might be contested because there may not be universal agreement that tobacco products are in the class of "biological, pharmaceutical and similar products." However, I would argue that this would be less of a problem if used in conjunction with a framework treaty rather than, as considered here, being the sole legislative instrument.
[Official Records WHA49/1996/REC/1, A49/4].

[44] 48th World Health Assembly, May 1995, Official Records WHA 48.14.

[45] Executive Board, 97th session, November 1995, Official Records EB97/9, 'Review of the Constitution of the WHO. Report by the Director-General' at p.4.

[46] Contained in 52nd World Health Assembly, April 1999, Official Records A52/24, 'Amendments to the Constitution. Report by the Secretariat,' p.5.

Adoption of this proposal would be an exciting development, as it substantially broadens the prospective scope of regulations making them flexible enough to be of use to the WHO. Unfortunately, as yet, no decision has been made as to the amendment and even if an amendment resolution is passed it will be some time before it comes into effect as amendment of the Constitution is a slow and cumbersome process.[47] Reluctance on the part of some State parties to grant such legislative power to an international organisation may in part be due to the significant role that regulations have played in the EC system.

However, when dealing with health, some issues require a quicker response than is available through establishment of a treaty system. As noted above, regulations were designed to deal with technical health issues where there is normally less political controversy. Thus, when such issues have arisen states have accepted voluntarily technical standards that have been adopted instead of regulations for subjects beyond the current scope of Article 21. The use of regulations in such circumstances, however, would have been preferable since they would have provided legal obligations on State parties and, therefore, a greater measure of certainty that the policy would be implemented with a global standardisation of results. This can be particularly important when reacting to health issues. Regulations also can be modified more easily to react to changing circumstances. Furthermore, drafting and adoption of regulations is much easier and quicker than for treaties.

Although regulations, in a manner similar to treaties, enable the organisation to develop a system of international legislation, states retain ultimate control. The need to attain universality has often been the rationale of the WHO for its reluctance to use these legal powers. Reservations certainly do have the potential to limit the impact on a state of its legal obligation but this can be successfully restricted within the existing system. Article 107 of the International Sanitary Regulations expressly precluded the automatic validity of reservations; instead assent of the WHA was required and this could be withheld if it was considered that it would substantially detract from the character and purpose of the Regulations.[48]

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[47] In practical terms it is very similar to the process used to implement a treaty. To date there have been 8 proposed amendments under Article 73 but only 5 have entered into force and these have taken from 5 to 10 years to do so.

[48] The position was clarified by the WHA [see Fifth World Health Assembly, 1952, Official Records No.37, pp.212, 276-78] after a similar clause had been omitted from the Nomenclature Regulations on the grounds that Article 22 of the Constitution did not impose any limitation on the nature and extent of the reservations which could be submitted.
[First World Health Assembly, 1948, Official Records No. 13, pp.99, 335].

According to Fluss:

> "This procedure has led in practice to a form of consultation between the reserving State and the Organization under which a number of reservations offered have been withdrawn or attenuated, or accepted subject to a time limit, followed by further review."

Approved reservations are considered to be reciprocally applicable to the reserving states, unless the reservation does not lend itself to reciprocal treatment.[49] In this way, it is possible for states to clarify their position in relation to a particular regulation and the ensuing discussion process should prevent the regulation from being undermined, although it remains possible that a state may ultimately decide to reject the regulation instead.[50]

To date, the role and significance of regulations within the WHO system has been minimal despite the consensus among Member States that, at least in relation to the International Health Regulations, the system has served adequately and continues to serve the principles as originally envisaged.[51] Recent consultation, concerned to improve the effectiveness of the International Health Regulations, has focused predominantly on establishing a broader and more effective reporting mechanism.[52] The suggestion has also been made that a practical handbook, in which the necessary criteria for international reporting would be defined, along with explanatory notes to facilitate their use, should accompany the revised Regulations.[53] This would be useful to ensure a more uniform interpretation of the Regulations but the handbook has the potential to be expanded to contain technical recommendations relating to the Regulation. In this way, a functional system could be established, which has legal effect in relation to the

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Initially, 25 Member States submitted some 73 reservations to the International Sanitary Regulations but of these 38 were rejected as incompatible with the purpose of the Regulation and most were eventually withdrawn so that the Member States became bound by the Regulations [Fluss and Gutteridge (1993), p.18-WHO].

[49] Resolution WHA5.32 adopted (under recommendation from its working party and the ad hoc committee) the position that reservations accepted by the Assembly should be applied not only by the state making the reservation but also reciprocally by each other party to the Regulations in its relations with the reserving state.
[Fifth World Health Assembly, 1952, Official Records No.42, p.26. Reproduced in Yemin (1969), p.199.]

[50] Rejection has to be within a limited period: three Member States did not keep the deadline in submitting reservations to the International Sanitary Regulations and were, consequently, regarded as bound by the Regulations *in extenso*.
For further details see Skubiszewski (1965-1966), p. 223.

[51] 49th World Health Assembly, May 1996, Official Records WHA49/1996/REC/1 'New emerging and re-emerging infectious diseases, and revision of the International Health Regulations.' A49 6 Add.1 (4).

[52] See A52/9 for a progress report on the revision and updating of the International Health Regulations.
[52nd World Health Assembly, April 1996, Official Records A52/9, 'Revision and updating of the International Heath Regulations: progress report. Report by the Secretariat.']

regulation, but also has a measure of flexibility to react to practical circumstances through easy amendment of technical recommendations provided in the accompanying handbook.

It is possible, as Schacter and Joyner suggest that it was the unambiguously binding character of regulations that made them politically unpopular. [54] Certainly, the only utilisation of this power was early in the WHO's history, when the regulations adopted were very similar in nature to the various conventions and agreements that they were designed to replace. Such an approach may have caused states to regard regulations as a system merely designed to circumvent state consent. In recent years, new issues in international health and recognition of the need for globalisation through effective legislation has led to a greater awareness of the potential for regulations and an increased willingness among states to at least consider the option. Rejection relates more to the restricted scope of Article 21, particularly when compared with the general statement of the WHO's functions under Article 2, and concern to avoid accusations that the organisation has acted *ultra vires*. If regulations are really to attain their full potential some amendment to the Constitution along the lines discussed in 1999 will be necessary. Adoption of such an amendment to article 21 would also be a formal endorsement of a more legislative approach to tackle global health concerns. It would provide the WHO with the necessary mandate to establish legal standards so that the organisation could respond more quickly to address essential health concerns.

**D. Recommendations**

There is some confusion as to the precise legal nature of recommendations. Under Article 23 it is difficult to interpret a recommendation as being other than persuasive with no binding legal power. Yemin, however, prefers to describe it as 'a facultative legal force'[55] thereby hinting at a measure of legality. There are actually a number of different mechanisms that are used by the WHO that have the effect of recommendations. These are: resolutions, codes of conduct, technical standards and other recommendations.

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[53] Official Records WHA49/1996/REC/1, A49/6 Add.1 especially (6) i-iv.
[54] Schacter and Joyner (1995): United Nations Legal Order, (vol. I and II). American society of international law and Cambridge University press at p.132.
[55] Yemin (1969), p.183.

i) *Resolutions of the World Health Assembly*

Analysis by the previous Director-General suggested that resolutions draw international attention to important issues quickly while allowing Member States flexibility as to their implementation. He also concluded that states were under no legal obligation to implement resolutions.[56] Fluss and Gutteridge have suggested that the process of adopting resolutions "borders on the legislative"[57] but this is simply recognition of the highly technical issues being developed. The use of resolutions has proved to be a simple, efficient means of transferring information quickly. In legal terms, such resolutions can only be considered evidence of the material element of custom (not with the same persuasive power as UN General Assembly Resolutions) but this is not to deny that such international consensus can be influential.[58]

ii) *Codes of conduct*

Codes of conduct also allow flexibility in implementation but are usually more detailed than a resolution. Often they may call upon governments to pass national legislation and urge industry to adhere voluntarily to the provisions of the code, but as with resolutions, there is considered to be no legal obligation for their implementation. It is important to note that negotiating and implementing an intergovernmental code of conduct may at times also be a slow process.[59] Some codes of conduct can be so technical and specialised that they are in many ways similar to technical standards, whereas other codes are designed to establish broad outlines. The Codex Standards[60] have been described as "a mixture of binding and soft law" because

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[56] A49/4 Implementation of resolutions, VI Tobacco or health, 3a.
The Director-General went on to report that the WHA has adopted 14 resolutions calling for comprehensive tobacco control policies, but a number of Member States have not fully implemented such policies.
[Official Records WHA49/1996/REC/1].

[57] Fluss and Gutteridge (1993), pp. 34-WHO.

[58] The difficulty in assessing the effect of resolutions was clearly illustrated in the *Legality of the Threat or Use of Nuclear Weapons case* [(request for Advisory Opinion by the General Assembly of the United Nations), 1996 ICJ Reports].
See particularly p.26 para.68 and paras.70-71.
Analysis of relevant UN General Assembly resolutions was that:

> "The focus of these resolutions has sometimes shifted to diverse related matters; however, several of the resolutions under consideration in the present case have been adopted with substantial numbers of negative votes and abstentions; thus, although those resolutions are a clear sign of deep concern regarding the problem of nuclear weapons, they still fall short of establishing the existence of an *opinio juris* on the illegality of the use of such weapons" (p.26 para.71).

[59] A49/4, VI Tobacco or health, 3b, giving as an example the draft UN Code of Conduct for Transnational Corporations which was negotiated from 1976 until the project was suspended by the General Assembly in 1994.

[60] Formed in 1963, the Codex Alimentarius Commission is a joint FAO/WHO project responsible for the implementation of a food standards programme. The Codex Standards were formulated as

they contain "*compulsory standards* as well as provisions of an advisory nature in the form of codes of practice, guidelines and other recommendations" (emphasis added).[61] Yemin equally asserts that recommendations in the 1967 amendment to the Nomenclature Regulations have a legal force "somewhat greater than that imparted by Article 23".[62] This may be the product of the inter-relationship of the recommendation to the regulation, and for states in practical terms, used to dealing with the issue as a regulation, it is easier to handle amendment of the recommendation in a similar manner as the corresponding regulations. Similarly, in practice the nature of the code may be such that certain key elements have to be accepted as 'compulsory' in order for the code to function at all. In legal terms, however, it is difficult to justify the hypothesis that codes of practice have a binding element. Their legal effect is purely persuasive.[63]

iii) *Technical standards*

Normally produced by expert committees and ad-hoc working groups, these technical standards provide specialised data and guidelines that are of particular interest to health authorities, e.g. food irradiation or drinking water quality. The fact that the issues dealt with in this manner tend to be technical and not political ensures that, within their field, they can have an important impact but, like all recommendations, this is a pragmatic rather than a legal approach to these health issues.

iv*) Other recommendations*

Of particular importance are the numerous WHO booklets and publications produced each year. Although not binding in themselves, "they have been widely adopted and are considered by the health services of most Member States to be a corpus of rules that should be respected".[64]

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recommendations, at least in part, because the category of food was omitted from Article 21 of the Constitution on the adoption of regulations in contrast to Article 2(u).

[61] Vignes, C. goes on to comment that the International Code of Marketing of Breast-milk Substitutes, as of 1995, has been applied in whole or in part by 160 countries and territories. While this is a relatively high take up rate, it suggests a selective discretion being utilised by Member States.
[(1995): 'Towards the harmonization of health legislation: the role of WHO'. Vol.46 International digest of health legislation, pp.422-427 at p.425.]

[62] Yemin (1969), pp.184 -5.

[63] And can be very persuasive. According to a WHO report in 1996 since the adoption of the International Code of Marketing of Breast-milk Substitutes, 1981, 149 Member States (i.e. 78%) have reported on steps they have taken to give effect to the International Code. Indeed, since 1994, 26 Member States have taken new, predominantly legislative, action concerned to give effect to parts of the Code.
[Official Records WHA49/1996/REC/1, A49/4].

[64] Vignes (1995), pp.425-6, prefers to differentiate recommendations by the way that the text is adopted.

Recommendations, in their various forms, have been the most popular tool used by the WHO to attain its objectives. This has been made easier by the open-ended nature of Article 23, which presents few limits on its use. In practice, the WHA has found it necessary to develop criteria to limit the scope of possible recommendations. These criteria include ensuring international feasibility and acceptability, the universal nature of the problem, the possibility of assessing results and financial feasibility to restrict its usage on health issues.[65] Recommendations, in all forms, have been very influential and should continue to play an important role in the furtherance of the WHO's agenda. The total delegation of discretion of implementation to Member States, while lessening potential political tensions initially, can lead to wide variations of approach. In the health field, in particular, this may not be a satisfactory outcome. Some health issues can be resolved internally by each country but others require a co-ordinated global response. For too long the WHO has relied solely on its power to make recommendations, and despite its best efforts, has not been able to avoid political controversy and international criticism. It is very significant that the organisation is beginning, at last, to look beyond recommendations to attain its objectives.

**E. Obligation to report**

With respect to all legislative powers, binding and non-binding, there is an obligation under Article 62 of the Constitution, for each member to 'report annually on the action taken'. States conform to this obligation extremely erratically and the WHO has shown little willingness to enforce it.[66] This neglect has been the object of much academic criticism particularly when comparison is made to its successful application in other international organisations.

> "Unlike WHO, ILO has transformed a procedure of government self-reporting to the organization into an effective supervisory mechanism that encourages compliance with ILO standards. ILO has developed an auditing procedure whereby, in addition to governments' submitting annual or biennial reports, an independent technical committee conducts regular audits to ascertain each state's compliance with ILO standards and the Conference Committee on the Application of Conventions and Recommendations publicly debates these findings."[67]

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[65] Executive Board, 5th session, 1950, Official Records No. 25, Annex 5, p.30 and Executive Board, 41st session, 1968, Official Records EB 41/2X.

[66] This may well be related to the discretionary nature of recommendations and need not prevent more effective implementation as part of a legislative system.
The WHO will have to adopt a more proactive approach if it is to successfully monitor and ensure effect is given to a Framework Convention on Tobacco Control.

[67] Taylor (1992), p.337.
"According to one observer, this procedure "has turned into a worldwide public hearing that clearly induces more compliance by governments than the threat of any intergovernmental legal action would."

At the International Health Conference, 1946, the Belgium delegation proposed adoption of a procedure to govern formal recommendations to members based on the practice of the ILO.[68] This procedure would have pledged Member States, within eighteen months, to bring each recommendation before the authority or authorities competent to enact legislation or to take other appropriate action. Unfortunately, instead of been recognised as a necessary mechanism to ensure conformity and consistency in state practice, this proposal was rejected because it was felt that there would be too much overlap with other legislative powers. I would propose that Member States should report to the WHO on action taken to enact formal recommendations within eighteen months. These reports should also be sent to the national organisations concerned with health in each country, which may submit comments. This system has proven to be successful for supervising and monitoring the implementation of ILO standards.

**F. Conclusion**

The WHO has a measure of legislative or quasi-legislative power which to date has been sadly under-utilised. This may be due to the ethos of the organisation and its ambivalence to the rule of law, or it may be general satisfaction with the level of influence that policies have so far achieved. It cannot be denied that there are some difficulties inherent to the international public law system but the manner in which any normative or prescriptive document is developed has significant importance. The WHO has the structure and expertise to ensure a high level of integrated consultation or 'health democracy' that needs to be utilised to move away from generality to elaborating and crystallising positions based on the right to health.[69]

There is a growing recognition within the organisation that issues of particular importance to the general international society may require a new approach. Rather than the traditionally pragmatic and low key approach to areas of concern, at this stage in international affairs it is important for the WHO to develop an

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[Sands, P.(1991): 'Lessons learned in global environmental governance.' Vol.18 British Columbia Environmental Affairs law review, p273 as quoted Taylor (1992), p.337, fn246.]

[68] International Health Conference Proceedings and Final Acts, 1946, Official Records No.2, p.21.

[69] For an example of one possible approach see Official Records EB97/16, para.22. It recommends establishing a steering group at the international level to guide and co-ordinate the process, a research-action group to monitor methodology, regional focal points and theme groups to orchestrate public debate on the ethical aspects of health policy and international health co-operation. However, its objective remains the global network for exchange of experience, which retains the tentative, non-assertive approach to international health.

effective, systematic and more assertive approach to these issues. The Constitution of the WHO does provide the necessary powers to achieve this. The option of using treaties, regulations or recommendations allows for a flexible approach to international health. The right to health could benefit from the appropriate use of this array of legal powers. Rather than consider each legislative power in isolation, perhaps by using the full array of powers available to the WHO, a more pragmatic, adaptable treaty system could be developed. One option would be to develop a treaty-based system to set in place a legal framework, acting as the focus for international consensus, with regulations, in conjunction with protocols, providing the more specific measures envisaged as essential to achieving the established goals. Furthermore, with the current array of international health issues to be addressed, it would be important to amend Article 21 to allow broader use of regulations. Recommendations would still have an influential role in interpreting and explaining regulations as well as retaining their important function with regard to highly technical standardisation. With such a system, it is not difficult to envisage the WHO as being extremely influential in the development of normative standards in international health.

The approach adopted by the WHO to tackle tobacco control suggests a willingness to use international law to address health issues. It suggests a shift in the organisation's ideological position away from medical exclusivity towards recognition of the political, economic, moral and legal implications of health. Hopefully, this framework convention and its accompanying protocols will be successful, thereby providing the WHO with the confidence to consider using a similar approach to address other important international health issues. One future project could, perhaps, be the drafting of a Framework Convention on the Right to Health.[70]

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[Executive Board, 97th session, January 1996, EB97/16, 'Ethics and health, and quality in health care. Report by the Director-General'].

[70] See chapter 8 for further details of this proposal and Annex III for a draft version of the first part of a Framework Convention on the Right to Health.

## 8.
## Policy approaches to develop the Right to Health

### A. Potential impact of the right to health on the policy of the World Health Organisation

Clearly, the level of impact that adoption of a right to health approach would have on the WHO is dependent on the level of WHO's commitment to such an approach. I would argue, that if the WHO is going to respect its legal obligations, then failure to recognise the right to health is no longer an option. In the past, the WHO has sought to obviate these obligations with periodic formalised acknowledgement but human rights concepts have had little substantive impact on policy. With the increasingly vociferous approach of the Committee on Economic, Social and Cultural Rights, in particular, such an approach is no longer feasible. The minimum commitment that the WHO must undertake is to ensure that its policy is in conformity with human rights obligations as established in the two international covenants and to actively seek to promote these rights through co-operation and co-ordination.[1]

Adoption of the right to health would not necessarily require significant constitutional amendments or structural reform instead the major change required is to re-focus the mind-set of the WHO to inculcate the right to health as its core principle. The greatest impact on the WHO would be in relation to the functioning of the organisation. As has been established, adoption of the right to health would require the WHO to become an advocate and protector of the right. The former role would impact most strongly on the WHO's policy focus and direction whereas the latter role would force a greater level of collaborative technical assistance and a more critical analysis of state conduct by the WHO.

### B. The World Health Organisation as advocate for the right to health

The WHO can only be a proponent of the right to health once it has established a consistent policy approach within the organisation itself. This will then necessarily impact on its external relations with other international organisations, non-party states and non-governmental organisations. Initially, re-orientating existing programmes will be the simplest way to most easily achieve this, but to be effective in the longer term, the WHO needs to develop new programmes specifically directed to promote the right to health.

**1) Re-orientating existing programmes**

Re-orientating existing programmes would require a greater understanding of human rights concepts and obligations within the organisation, which would then be transposed onto these existing programmes. However, a greater use of rights terminology would not in itself be sufficient. Instead there would need to be accompanying consistent policy objectives and focus that reflect the obligations and duties associated with the right to health.[2] For example, with regard to disease eradication programmes, this approach would require broadening the reach of these programmes. These programmes would now have to consider the broader context of their work. In relation to the research itself, this would include best practice as a requisite but would also mean assessing the potential impact of eradication programmes to ensure equality of access to treatment, non-discrimination in the provision of health care services and uniform provision of information. Another essential component would be a social and economic impact assessment of the disease eradication programme on the communities most greatly affected by its implementation. This would require a greater level of early dialogue between the community and researchers and greater access to information and collaboration with other agencies to ensure sufficient resources are available to enable the community and states to manage any consequential effect.

So even in relation to a 'vertical' programme a more holistic effect consistent with the right to health can be achieved. Indeed, the international approach to HIV/AIDS has shown how effective and important such an approach can be. Yet this methodology has not been transposed to address other diseases currently attracting the attention of the WHO. Efforts directed at malaria and TB could be managed in a similar manner, as could non-communicable diseases such as cancer, cardiovascular disease, diabetes and chronic respiratory diseases.[3]

Tobacco could also be approached in a similar manner except that the WHO is already committed to using a Framework Convention on Tobacco Control as its focus. While I have some concerns with the proposed framework convention, there is still enough flexibility within the drafting procedure to enable human rights

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[1] Refer to chapter 3 for details.
[2] Ibid.
[3] Diseases identified by the Director-General as priority areas for the financial year 2002-2003. I am using these identified priorities simply as examples to show in practice how easily any WHO 'vertical' programmes could be re-focused.

issues to have a significant role in the final convention system.[4] Despite its title, a great deal of the substance concerns and impacts upon the economic and social rights of the individual, community and state, yet these human right issues have received little attention[5] (except, of course, for the proposal for an obligatory mention in the preamble, although this option for consideration only arose at the first meeting of the working group on the subject).[6] Instead, the approach adopted is utilitarian and even runs the risk of placing undue emphasis on individuals to maintain their own health status.[7] It is also important to differentiate between the indirect impact potential of a particular approach on the right to health and the explicit use of the tools and principles of human rights to develop and direct policy. The latter approach may be more politically sensitive but it is more likely to facilitate protection of an individual's rights.

Other priority areas for the year 2002-2003 are health systems, maternal health and mental health. Each of these has already received a great deal of attention at the international level in relation to human rights obligations and could easily be re-orientated. Existing programmes concerned with maternal health and reproductive health within the WHO are already considering these issues within the context of human rights. Even here, however, the right to health itself has received scant attention. It would be reasonably straightforward to use identified state obligations in relation to the right to health as a blueprint to assess and strengthen health systems. Indeed, the matrix formulation developed by Toebes[8] could prove to be a useful tool to begin to determine the priorities and weakness in health systems especially when considered in conjunction with the recent General Comment No. 14 adopted by the Committee on Economic, Social and Cultural Rights.[9] Similarly, CEDAW[10] and several of the UN Conferences[11] have identified priority

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[4] Refer to Chapter 7.

[5] Possible topics for inclusion in protocols include: tobacco price and tax policies, environmental tobacco smoke, protection of children and adolescents, information exchange, health education and research and agricultural policies.
[WHO report, October 1999, A/FCTC/WG1/7, 'WHO Framework Convention on Tobacco Control. Report of the first meeting of the working group.' para.78.]

[6] Ibid., para.23:

> "Primary attention should be given to the health effects of tobacco use and the harmful effects on national economies. The importance of a focus on youth, women, disadvantaged groups and indigenous people was highlighted... For that to occur, the framework convention should refer to other conventions that addressed youth behaviour, such as the Convention on the Rights of the Child. Another suggested addition to the preamble was to refer to the WHO Constitution."

Would that be to emphasise health as a fundamental human right?

[7] This would be contrary to accepted mainstream human rights theory (see discussion in chapter 4).

[8] See 'Matrix: tripartite typology of state obligations' found in Toebes (1999), pp.314-315.

[9] Reproduced in Annex II.

[10] For details see chapter 2.

[11] Ibid.

areas in relation to maternal health and mental health and have thereby established a useful basis on which WHO programmes could build.

Similarly, programmes concerned with safe blood and food safety should be considered as essential elements of the right of the individual to maintain and protect her/his own health status. This, in turn, would give rise to corresponding state obligations to protect and fulfil obligations in relation to health care and underlying preconditions for health respectively.

Indeed, the new focus for the WHO, 'health and poverty,' is a particularly nebulous concept unless grounded in human rights. One report by the Director-General goes so far as to admit adoption of this policy is based on the fact that "[v]irtually all agencies have adopted a poverty focus in their work".[12] But, the desire to align with other international organisations to improve co-operation and co-ordination should ideally be a positive move for the WHO as well. However, there is a danger in focusing on the links between health and poverty reduction if it is not done within the context of human development, humanitarian action and human rights. At least a measure of the potential problem has been recognised by those advocating the new approach but the level of commitment to human rights remains to be seen.[13] Using the right to health as a tool to direct the WHO's position on poverty is the essential next step. Unfortunately, a step that has not yet been considered by the organisation.

Within the confines of this thesis it is not possible to consider all the current programmes to assess whether re-orientation would have a positive effect. But, at least in relation to the corporate strategy that is currently being developed, the right to health would certainly seem to have an important role. In fact, with regard to 'health and poverty,' such an approach would be essential.

**2) Development of new programmes**

Because of the potential scope of the right to health, there is a range of possible new programmes that the WHO could consider. Indeed, one of the principal reasons why the WHO should adopt the right to health

[12] Executive Board, 105th session, December 1999, Official Records EB105/7, 'Working in and with countries. Report by the Director-General,' para.7.
[13] Executive Board, 105th session, December 1999, Official Records EB 105/3, 'A corporate strategy for the WHO Secretariat,' para.9.

is to establish a structure of concepts and objectives that permeates all the work of the organisation. Having said that, there are certain segments of the right to health that clearly need to be developed further and would, therefore, benefit from the focused attention that is implicit in a programme framework. The WHO has valuable expertise to develop the substantive aspects of the right to health. There is a desperate need for greater interface between human rights theory and health policy in order to ensure that the right to health has practical effect. In this context, notions of non-discrimination in health and empowerment of the individual are of particular concern.

i) *Revitalise Health for All in the Twenty First Century*

The WHO's Health-for-All programme has had a significant impact on the future development of international health policy such that it would be unfortunate if the programme were to be completely discarded.[14] Health for All in the Twenty First Century[15] should be re-formulated based on the General Comment by the Committee on Economic, Social and Cultural Rights so as to encourage states to meet their obligations under the right to health.[16] Such a programme would be particularly useful in assisting states to achieve the core obligations as identified in the General Comment and assisting donor states to direct aid towards the same ends. Development of health care systems is a powerful social construct towards establishing a particular approach towards health and should be viewed as such by the WHO. Therefore, assisting states to meet their obligations under the right to health care does not just involve the providing of technical expertise but also involves ensuring that the health care system reflects the needs of the society in which it is located. This, in turn, would require the WHO to encourage states to ensure greater public participation in all aspects of development of health policy.

ii) *Equality (and non-discrimination) in health*

Equality[17] and non-discrimination[18] are fundamental principles of human rights philosophy and yet, particularly in relation to economic, social and cultural rights, the precise nature of the obligations

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[14] For details of the policy refer to chapter 4.

[15] Ibid.

[16] UN Committee on Economic, Social and Cultural Rights: The right to the highest attainable standard of health: Comment 14 (General Comments). UN Doc. E/C.12/2000/4.

[17] "The idea of human rights assumes that all human beings have some basic, commonly shared characteristics, and that as a result they should be viewed and judged as members of the human race rather than as members of a particular group. The recognition of these shared qualities gives rise to a principle of equality which requires that all persons be treated with equal respect."

enshrined remains unclear.[19] To date, health ethics and professional values have acted as the driving force behind the WHO's initiatives regarding equality and non-discrimination. But the ICESCR goes further in that it establishes immediate legal obligations on state parties to undertake to guarantee that relevant rights 'will be exercised without discrimination...'[20] Unfortunately, the precise nature of these obligations, particularly in relation to the right to health, remains unclear and the situation is further complicated by recognition that:

> "the existence of *de facto* discrimination, as evidenced through material inequalities and individual prejudice, is a matter that necessitates longer-term social and educational programmes aimed at eliminating discrimination in a progressive manner."[21]

Still, the WHO has a responsibility to aid Member States in their efforts to give effect to these obligations. Also because notions of equality and non-discrimination necessarily impact on all policy or programmatic implementation of the right to health consistency of approach is essential.

A clear understanding is also needed of the relationship between equity and equality in health. Equity is a notion commonly used in the context of social development policy and yet does not have a clear definition. It is a non-legal generic term that seeks to give practical effect to the legal notions of equality and non-discrimination. Equity is a term used to direct the discretionary power of governments, non-state actors and international organisations to determine policy that reflects the broader notions of equality beyond the

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[Craven, M. (1998): The International Covenant on Economic, Social and Cultural Rights: A perspective on its development, p.154].

[18] Refer back to Chapters 2 & 3.
Also, Craven considers that the concept of non-discrimination is primarily a legal technique employed to counteract unjustified inequality but it can serve as a useful tool to delineate equality.
[Craven (1998), pp. 152-193]
Craven provides a good analysis of non-discrimination and equality particularly in relation to the ICESCR but see also Klerk, Y. (1987): 'Working paper on Article 2(2) and Article 3 of the International Covenant on Economic, Social and Cultural Rights.' Vol. 9 Human rights quarterly, pp.250-267 and Judge Tanaka's dissenting opinion in the *South West Africa Cases* (Second Phase), (1966) ICJ Rep. 6 at pp.284-316.

[19] Craven, in his book, suggests that there is manifestly a need for the Committee to make some clear statement as to its position on the subject.
[Craven (1998), p.193].

[20] As interpreted by the Committee on Economic, Social and Cultural Rights in its General Comment No.3, para.1.

[21] Craven (1998), p.182.
While recognising that *de jure* discrimination may be eliminated immediately by the creation and enforcement of relevant legislation, this could equally involve considerable financial expenditure to be effective.
Klerk argues that a distinction can be made between the use of legislative and non-legislative measures to eliminate discrimination. Thereby allowing that the latter obligation can be more gradual but still managed 'speedily'.
[Klerk (1987), pp. 260-264 and 267].
Toebes seems to favour interpreting Articles 2(2) and 3 of the ICESCR as having immediate effect only.

technical legal definition. More work, however, is required to establish the inter-relationship of equity, equality and non-discrimination and their subsequent impact on health. The WHO is uniquely positioned to facilitate and collaborate on such research.

The objectives of a WHO programme in regards to equality and non-discrimination in health would be predominantly concerned with the progressive element of these obligations.[22] The goal would be to help Member States establish and continually seek to re-focus a process of equalisation in their actions regarding health policy.[23] The essential function for such a programme would be to use the principles of 'respect, protect and fulfil' in relation to health care and health status to more narrowly define in practical terms the obligations placed on state parties. In this regard, the programme should build on the examples provided in the General Comment on the Right to Health.[24] Substance also needs to be given to paragraph 19 of the General Comment, particularly to such notions as 'equal access to health care and health services' and '[i]nappropriate health resource allocation'.[25] Further consideration is also needed of these terms with particular reference to vulnerable groups. CEDAW in its General Recommendation on 'Women and Health'[26] stated that:

> "special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities."

The ICESCR itself simply lists 10 prohibited grounds for discrimination ("race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status"), which have since been expanded on in the General Comment on the Right to Health adopted by the Committee on

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[Toebes (1999), pp. 292-293 and 296].

[22] While clearly some states would also need practical and financial assistance to combat *de jure* discrimination as well, the main role for the WHO in this regard would be to assist the Committee on Economic, Social and Cultural Rights as well as to monitor state action and critique reports.

[23] It is the opinion of Craven (1998), p.160 that:

> "even when the 'minimum core content' of the rights is achieved for all persons, the State may be seen to be under an obligation to ensure that everyone has equality of opportunity or access to higher levels of the rights concerned."

If the ultimate aim remains the 'highest attainable standard of health' then this would seem to be a logical assumption with regard to the right to health.

[24] UN Committee on Economic, Social and Cultural Rights: Comment 14.

For example: "vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes." [Para. 18.]

[25] Reproduced in Annex II.

[26] United Nations CEDAW General recommendation No. 24, 'Women and health.'(Twentieth session, 1999, UN Doc. A/45/38), para. 6.

Economic, Social and Cultural Rights.[27] Research and normative strategies need to be developed that ensure the human rights concepts of equality and non-discrimination interface with the practical implementation of the right to health. Such a process will be difficult for the Committee on Economic, Social and Cultural Rights to develop alone. The WHO is well placed to facilitate development in this field and also to monitor and assess the impact of this process by effective co-ordination of the various programmes within the organisation as they seek to implement these initiatives.

iii) *Empowerment*

For some time as part of its Health-for-All programme, the WHO has been working in the area of empowerment but also within the broader ambit of public health.[28] Generally, though, there has been little interplay between the two and both have been seen as ends in themselves rather than the means to give practical effect to human rights generally or the right to health in particular. There are currently several identifiable elements within the notion of empowerment each of which is in need of further development through research. The WHO should be involved in furthering the effective dissemination of health information and developing the role of health education, facilitating development of social identification with the right to health, encouraging development of health legislation and expanding public participation in the processes concerning health and the right to health.

Education and the dissemination of information has long been considered within the sphere of public health but only in recent years has consideration been given to the interplay between health education and human rights.[29] Both the Beijing Conference on Women and the Cairo Conference on Population and Development highlighted the significant role of access to 'objective' information and education as tools to facilitate individual empowerment.[30] More research is needed as to how individuals are deprived of control

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[27] Article 2.2 of the ICESCR. For the expanded version see para.18 of the General Comment on the Right to Health, reproduced in Annex II.

[28] Refer to chapter 4.

[29] Medical ethics has tended to focus on notions of informed consent and professional education while public health has primarily sought to encourage modifications in personal behaviour to improve social standards of health.

[30] Refer to chapter 2.
Because of the focus of these conferences particular attention was given to access to information on family planning and pre- and postnatal care. Certainly, important issues where access to information is essential but not the only areas of concern to which the WHO should direct attention.

over their health and how individuals create themselves, their world and their power relations in order to better identify the methods and means of providing information and education in this regard.

Empowerment of the individual and the community is negated if the focus is simply placed on pressuring individuals to take responsibility for their own actions. While individuals have to be responsible for their own actions, focusing solely on individual responsibility fails to recognise the role that social, political and cultural structures in society have on individual choice and decisions.[31] The right to health can be used to broker an effective relationship between the individual, the notion of community and social health needs but more research is needed to give this practical effect.

Similarly, within the public heath context, consideration has been given to social and economic incentives and disincentives that affect individual decisions. By moving away from a medical model of health, the WHO has started to consider the broader position of the individual and the correlating social impact on health. Development of the programme on poverty and health is an example of this. If the right to health is to have meaning for individuals and local communities, more work is needed to facilitate social identification with the right to health itself. This may well involve greater co-operation with activist non-governmental agencies that have experience working with human rights to bring about a greater social understanding and identification with the right to health.[32]

The need for health legislation based on the right to health is an essential component of empowerment because it institutionalises human rights principles and thereby provides an avenue of accountability and recourse. Currently, the WHO correlates health legislation through the 'International Digest of Health Legislation' and in so doing enables states to monitor and develop legislation through comparison. But this is a limited approach when the WHO, as the predominant international institution on health, is in a unique position to advocate for and impact on the content of health legislation.[33] Certainly, having an international

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[31] Discussed in more detail in chapter 5.

[32] Ultimately, this may lead to recognition of the need for social change but this is not the goal. The goal is to encourage a greater understanding of external pressures on individual health and enabling the individual a greater measure of control.

[33] Fidler has identified to be truly effective in this area would require the WHO to expand its health legislation department to include public international lawyers.
[See Fidler, D. (1998): 'The future of the World Health Organization: What role for international law?' Vol.31 Vanderbilt journal of transnational law, pp.1079-1126].

treaty that clearly articulates the content of the right to health would be a particularly useful starting point, as it would provide clear direction to states. However, even without such a treaty, the WHO is in a position to identify and expound normative standards and assist states to transpose these standards into domestic law. Inclusion of these standards would ensure an individual at least a measure of protection of her/his right to health within a domestic legal system.[34]

Full participation by individuals and society at all levels in the process of developing health policy has already been identified by the WHO as a further tool to facilitate personal empowerment and thereby assist human flourishing. Public participation has always been considered an integral component of the Health-for-All programme[35] but it is hard to find any evidence that its influence has spread to other programmes.[36]As already identified in Chapter 6, the WHO has a unique structure which is ideally suited within the international arena to facilitate this process but more research is needed as to how best to develop full participation as a 'means' as well as an 'end'.[37]

The UNDP has already done some interesting work to improve effective participation in projects at the local and community level. Their paper on 'Empowering people: a guide to participation'[38] could be a useful base from which to develop strategies to improve participation in health.[39] Further analysis of the consultation process used by the WHO prior to the drafting of the Declaration on Health could provide useful insight from which to develop strategies to improve dialogue at the international level. Full

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[34] Not all facets of the right to health are best protected by domestic laws. A state's discretionary power to provide health care and ensure the underlying preconditions for health may also require development of administrative, bureaucratic and political strategies of protection as well.
[35] Refer to chapter 4 for details.
[36] Other than in the broad consultation prior to the Declaration on Health discussed earlier in chapter 4.
[37] As defined in the UNDP document:
Participation as a **means**: participation is seen as a process whereby local people cooperate or collaborate with externally introduced development programmes or projects...
Participation as an **end**: participation is seen as a goal in itself. This goal can be expressed as empowering of people in terms of their acquiring the skills, knowledge and experience to take greater responsibility for their development...
[United Nations Development Programme: Empowering people: a guide to participation. http://www.undp.org/sl/Documents (last updated November 3, 1999), p.4].
[38]Ibid.
[39] The principle difference being that the UNDP document was concerned with developing good practice participation within an individual project cycle whereas here the concern is to have on-going public participation with regard to appropriate functioning in relation to health care facilities, resources and technological developments.

participation at all levels is essential and can only be achieved through improved dialogue.[40] Mechanisms to ensure a transparent system of communication[41] would be an important initial step towards the formalising of the individual's empowerment at the international level.[42] The WHO has the structure and facility to have a major impact on this process towards empowerment if the motivation were there. True advocacy of the right to health could be the essential catalyst to such a process.

A strong focus on the right to health would also serve to highlight and impact upon other programmes that are currently within the scope of the WHO. The difference with these new programmes however, as compared to the re-focusing of existing programmes, is the important impact that these could have on the development of the right to health itself.

iv) *Anti –violence programme*

While academics may disagree on some of the details concerning the right to health there is growing consensus as to some of the most obvious violations of that right.[43] Many of these violations can be categorised as violence against the individual. If the WHO is to advocate the right to health, there is a clear obligation to give priority to minimising violence and its effects. The majority of the issues that would come under this umbrella have already attracted the attention of the WHO but not within the framework of a right to health and a much more pro-active approach is required. [44] Also, the categorisation of theses issues as a group is, in itself, important as a tool to break down some of the artificial barriers between

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[40] See chapter 6 for a detailed discussion of the unique features of the WHO that could be adapted to facilitate this process.

[41] Essential to ensure confidence in the system and the first step towards democratising the international process.

[42] Ultimately, the aim would be to provide a conduit to articulate social consciousness. This may seem idealistic and extreme but as is made clear in the UNDP paper (chapter 1, p.5) it is important to view participation in terms of a continuum that has the capacity to move from nominal participation that represents little meaningful or direct involvement to a transformative participation that results in people's empowerment. To me there is no reason why this same process cannot build from the local to the regional and ultimately the international level with the right encouragement.

[43] Refer to chapters 2 & 3 for details.

[44] The WHO first formally recognised violence as a public health issue at the Forty-Ninth World Health Assembly in 1996 (WHA 49.25). It currently has a Violence Prevention programme that focuses on domestic violence, child abuse and violence in conflict situations (as requested in WHA 50.19). To date it has been concerned with developing an international classification of the external causes of injuries, data bases (on the prevalence of violence against women and data collection on landmine injuries) and is in the process of producing a 'World Report on Violence' to be released late 2001.
While this is important work, the focus appears to be solely on violence as a public health problem and the essential connection has not been made between public health and human rights (and certainly not with the right to health).

private and public and domestic and international concerns. Of particular importance to the WHO should be:

- Domestic violence
- Self-directed violence
- Infanticide
- Female circumcision
- Prostitution/pornography
- Slavery
- Prisoners
- Political violence
- Torture including rape
- War crimes
- Threat or use of nuclear weapons and other weapons of mass destruction

Many of these sub-categories are currently being addressed at the international level as well so there exists a clear need for the WHO to co-ordinate policy and work within existing projects. However, the WHO is uniquely placed to focus on the implications for the right to health that are a part of these projects. As part of this process the WHO could monitor, collect and correlate data suitable for the use by the relevant enforcement agency,[45] develop prevention strategies including legislation and educational packages, and establish detection systems for health professionals and co-ordinate fieldwork.[46] This would provide a formal, practical interface between public health concern for violence and violation of the individual's (and the corresponding local community's) right to health.[47]

[45] The WHO should be providing active technical support to UN War Crimes Tribunals, non-governmental organisations monitoring purported atrocities as well as UN bodies such as the Committee on Economic, Social and Cultural Rights.

[46] All based on a right to health framework.

[47] Violence in society is a good example of the interconnection between individual rights and needs, and the rights and needs of the local community. In my view, it is not rationally feasible to address and seek to protect one without being aware of the impact on the other.

v) *Scientific progress*

Although the WHO has some programmes concerned with biotechnology and health technology, it is currently concerned primarily with facilitating the dissemination of technical information and technical standards. [48] In so doing, the WHO seeks to provide objective material and thereby avoid consideration of the social issues that arise from the use of such technological development. Within the sphere of biotechnology, attention has been directed at establishing an essential drugs and medicines policy to address the problems of access, rational use and drug quality at the country level.[49] However, by adopting and implementing the essential drugs and medicines policy, does a state fulfil its obligations in relation to the right to health? I believe this is a useful minimum from which a state can gradually build to attain the highest available level of drug availability.

It is clear that the medical model serves as a useful means of deflecting consideration of the social implications for scientific progress. Adoption of the right to health as a core principle would serve to counter-act this tendency. The WHO would be under an obligation to facilitate a more open discussion of such issues and establish equitable standards based on non-discrimination. There are a number of new medical developments such as genetic manipulation therapy, cloning and the technological divide and its impact on which the WHO has so far avoided establishing a formal position.[50] The WHO, as a leader in international health and advocate of the right to health, should be utilising resources to monitor such

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[48] Examples of current concerns within the programme on Health Technology are blood safety, clinical technology (focusing on improving the quality of health care at the district level by identifying and promoting cost-effective procedures, equipment and materials; promoting the standardisation of procedures and equipment), health laboratory technology (development of appropriate policies, laboratory standardisation, quality assessment and assurance, laboratory management, safety and training), radiation medicine ( increasing access to diagnostic imaging and therapeutic radiological services while maintaining their quality and safety), and technology assessment and quality assurance.
[WHO, Programme on Health Technology, http://www.who.org/pht, p.1, 03/28/2000].

[49] The WHO mission in medicines for 2000-2003 includes as its main objectives:

- Policy
- Access
- Quality and Safety
- Rational use of drugs

By ensuring: 1) government commitment to national drugs policies, co-ordinated implementation by all stakeholders, and monitoring of impacts; 2) equitable availability and affordability of essential drugs, with a focus on priority health problems, and poor and vulnerable populations; 3) the quality, safety and efficacy of all medicines through strengthening and putting into practice regulatory and quality assurance standards; 4) use of therapeutically sound and cost-effective drugs by health professionals and consumers.
[For further details consult 'WHO and medicines: role and mission of EDM', http://www.who.org/medicines/edm-about.html, 03/28/2000 and 'The rationale of essential drugs,' http://www. who.org/medicines/edm-concept.html, 03/28/2000].

innovative research and establishing pre-emptive informed dialogue. This would enable the global community to develop a position on such technological progress and facilitate the adoption of formal guidelines.[51] The WHO also has the necessary legal powers to enable the international community to respond quickly as the social implications of innovations become apparent thereby facilitating protection of the right to health.[52]

vi) *Environmental health*

Fortunately, the WHO has already done a great deal of important work in environmental health. Certainly, understanding environmental health is essential if the right to health is to have practical effect.[53] An essential component of the right to health will be the development of appropriate indicators and strategies concerned with protecting and promoting the underlying preconditions of health, namely water and sanitation, environmental and industrial health and physical integrity. Much of the knowledge and expertise already acquired by the WHO's Department of Sustainable Development and Healthy Environments could be harnessed to this end.

The fact that the WHO already has programmes that relate to the concepts and principles contained in the notion of the right to health leads one to conclude that the organisation could actively seek to become an advocate for the right to health. Clearly, some adjustments would be necessary and funds may need to be

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[50] Although it has contributed to international debate on the subject in the form of roundtable discussions and contributed to the drafting of international treaties on these subjects.

[51] The WHO is uniquely structured (refer to chapter 6 for details) to feasibly co-ordinate and facilitate such a dialogue at all levels but would be particularly well placed to ensure public participation had a role in the process.

[52] Guidelines and regulations are useful tools to formulate a quick even temporary legal response to situations that would allow the international community time to respond in a more measured and effective manner. (Refer to chapter 7 for further details).

[53] The WHO is already concerned with the health implications of such subjects as: air quality, chemical safety, climate and health, drinking water quality, electromagnetic fields, environmental epidemiology, environmental health, environmental sanitation, food safety, healthy cities, noise, occupational health, radiation safety, solar UV radiation, water supply and sanitation, and pesticide evaluation; as well as broader social issues concerning the inter-relationship of health, environment and development and women, health and the environment.
Of particular interest are the general papers produced by the Department of Health and Environment in Sustainable Development that summerise the WHO's current position.
These include:
'Health and environment in sustainable development: Five years after the Earth Summit, Executive summary.' (1997)
[http://www.who.org/environmental_information/Information_resources/htmd.../execsum.ht, 03/28/2000], and

re-allocated, but generally the concern is more with the emphasis and focus of the programmes. A radical repositioning would not be necessary. Indeed, the WHO is poised to have an exciting impact on the development of the right to health if it should decide to adopt this approach. Were the right to health to become an integral component of all the policy initiatives by the WHO, it would also impact on the organisation's external relations by seeking to reflect these priorities in its collaborative programmes. As an advocate of the right to health, it would re-position itself within the international system and its outlook on the health implications of international policy may well be different. The broader implications crystallise when considered in collaboration with its other essential component role in relation to the right to health, namely as a protector or enforcer.

**C. As protector of the right to health**

Advocating a position is an important first step and in many ways it is the easier component of the right to health for the WHO to adopt. In reality, states and other affected agencies need stronger incentives to comply with the obligations inherent in the right to health. Certainly, there is already a limited international enforcement system in place[54] and, with minimal amendment to its constitution or structure, the WHO could position itself to enhance these existing mechanisms.[55] But the WHO also has the potential to establish new means to effectively implement and facilitate compliance with the right to health.

The major hurdle in accomplishing this is the WHO's phobia concerning politicisation. For the WHO, the role of protector would depend heavily on the ability of the organisation to change its collective mind-set. Mediation, negotiation and consensus would still have a role but the organisation would have to be much more pro-active and at times censorious to be effective. Admittedly, this would be much easier for the WHO to achieve if the necessary procedural mechanisms were sufficiently formalised and institutionalised. However, it is equally important to recognise that many of the essential functional elements necessary to protect or enforce the right to health require technical health expertise, already one of the strongest components of the WHO.

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Climate and Health: working group meeting, 18-19 May 1999. Protection of the human environment, occupational and environmental health series. WHO/SDE/OEH/99.6.

[54] Refer to chapter 1 and also see Craven's (1998) book for a detailed analysis of the mechanisms under the ICESCR and Toebes' (1999) book for further consideration of mechanisms to give effect to the right to health.

[55] Refer to chapters 6 and 7 respectively.

It is useful at this point to catalogue and assess the WHO's capacity to act as protector of the right to health. I will discuss this first in relation to State parties and then in relation to the UN system.

**1) <u>In relation to state parties</u>**

The WHO has near universality of membership and so is well positioned to encourage Member States to fulfil their obligations in relation to the right to health.[56] However, protection or enforcement of the right to health is impossible without access to information. The WHO has the capacity to greatly enhance effective protection and enforcement by using its expertise to collect pertinent data, write reports, develop indicators and develop assessment systems.

i) *Data collection*

The WHO is internationally recognised for its ability to collection and process data and information relating to health. Unfortunately, to date this ability has not been directed towards facilitating protection of human rights generally, including the right to health. Even if the material to be collected remains much the same, it would be necessary for it to be formatted in order to be of use to internal programmes focused on the right to health and external human rights bodies. However, currently the WHO is heavily dependent on Member States to collect and make available relevant data and, with some exceptions, there is no mandatory obligation for Member States to do so.[57] It follows, therefore, that the WHO should establish essential core material to be collected from each Member State.[58] There would also be an obligation to try to verify information provided by Member States. This would probably require greater co-operation with non-governmental organisations in the field and other international institutions that have the ability to verify certain information.[59]

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[56] Regardless of whether this obligation is considered to be contractual under the terms of the WHO's Constitution or derived from an obligation on international organisations to conform to human rights treaties.

[57] Exceptions being in relation to the International Health Regulations and other treaty obligations.

[58] Ensuring pertinent material is collected would be heavily dependent on the development of effective indicators. See below for further discussion of this issue.
The practical difficulties and expense of data collection experienced in relation to the Health-for-All programme reiterates the need for international co-operation and resources if this is to be effective. Refer to chapter 4 for details.

ii) *Use of reports*

At the moment, the WHO obtains copies of reports submitted by states to the Committee on Economic, Social and Cultural Rights but does little with this information. Without further resources, the Committee, itself cannot verify the content of these reports. The WHO is the only international organisation with the capacity to verify, analyse and evaluate effectively the information provided. At the very least, the WHO should undertake this task. In addition, it would be extremely useful to the Committee if the WHO were to produce a report of its own on the country being evaluated. The WHO seems reluctant, however, to place itself in such a position as it may then be incumbent upon it to criticise one of its members.

By shying away from this responsibility the WHO fails to take the opportunity to assist its members by presenting a comprehensive report that could be positive in its assessment, and at the minimum, provide useful guidance to direct future policy initiatives. The WHO does produce an annual world health report, which is a useful analysis of the health status globally, but it considers regions in general terms so as to be non-confrontational and therefore uncontroversial. There would be value in greater specificity through a more critical analysis with constructive criticism leading to specific recommendations. To be of use, there would have to be clear agreement between the Committee on Economic, Social and Cultural Rights and the WHO as to how the information could be provided in the most helpful format. This would require a much greater level of co-operation between the two, a much clearer understanding of state obligations in relation to the right to health, and greater consensus as to the framework of the right to health.[60]

iii) *Development of indicators*

If the right to health is to have measured accountability and be justiciable then development of effective indicators is an essential next step. The WHO is well placed to interface between health professionals and human rights experts to identify pertinent indicators.[61] The type and form of data and information collected

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[59] A more open system of access to statistical data needs to be established within the UN system. To be effective this would require system wide conformity regarding correlation of material.

[60] General Comment No. 14 by the Committee on Economic, Social and Cultural Rights on the Right to Health will have an important impact in this regard.

[61] As Yamin and Maine suggest in their article:

> "[a]s valuable as the rights perspective is, however, it is not sufficient. Without a sound understanding of the epidemiology of maternal mortality (and therefore, the interventions that can prevent it), the concept of a human right to be free from avoidable death during pregnancy and childbirth will remain meaningless. Without a clear understanding of the causal chain leading to

necessarily impacts on the way the right is defined and perceived by society.[62] When consideration was first given to the need to develop relevant indicators[63] the issue was avoided based on the notion that the concepts concerned lacked essential clarity.[64] But if the right to health is to have practical effect at some point these two issues have to be addressed simultaneously. Since the first consideration of indicators in relation to human rights in the early 1990's the international community has put considerable energy into trying to clarify the legal obligations contained in the concept of economic, social and cultural rights.[65] In relation to the right to health, in particular, the General Comment by the Committee on Economic, Social and Cultural Rights can be seen as the culmination of this work.

Before going on to add further indicators to the burden of those collecting the material, the important next step is to determine the most pertinent indicators from the vast array of material currently collected i.e. those that most effectively monitor the human rights principles contained in the right to health.[66] The issue of indicators was addressed at the Cairo Programme and the Beijing Declaration resulting in the adoption of certain indicators concerned monitoring aspects of the right to health but these will have limited utility because they are pre-dominantly impact indicators.[67] These indicators were: infant mortality, maternal mortality, infant immunisation and life expectancy.

Infant mortality

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maternal mortality (and how to break it), programs intended to reduce maternal deaths are likely to be ineffective."

[Yamin, A. & Maine, D. (1999): 'Maternal mortality as a human rights issue: measuring compliance with international treaty obligations.' Vol.21 Human rights quarterly, pp.563-607, 564.]

[62] There is an integral relationship between the concept and the indicator particularly in relation to human rights where compliance and violations are a primary focus.

[63] See Commission on Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities: The new international economic order and the promotion of human rights: Realization of Economic, Social and Cultural Rights. Progress Report prepared by Mr. D. Turk, Special Rapporteur. UN Doc. E/CN.4/Sub.2/1990/19, pp.1-105 and
Report of the seminar on appropriate indicators to measure achievements in the progressive realization of economic, social and cultural rights. Geneva, 25-29 January, 1993. UN Doc. A/CONF.157/PC/73, 20 April 1993.

[64] UNDP, Maria Green, (1999): What we talk about when we talk about indicators: current approaches to human rights measurement, p.3 footnote 1. (Draft copy with author)

[65] The work of the Committee on Economic, Social and Cultural Rights has been particularly influential in this regard.

[66] The burden of collecting this information is placed mainly on the national governments with some support from various international organisations. In relation to health, there are few non-governmental organisations that have a broad enough base in the field to be of assistance here.

[67] Yamin and Maine (1999), p.593.
Impact indicators describe the objective or subjective status at a point in time.

At the Cairo Summit on Population and Development, 1994, not only was it recognised that average infant and child mortality rates needed to be reduced but also the gap between the average rates in developed and developing countries should be substantially narrowed.[68] In addition, disparities within countries, those between geographical regions, ethnic or cultural groups, and socio-economic groups should be eliminated. Indeed, countries with indigenous people should achieve infant and under five mortality levels among their indigenous people that are the same as those of the general population. The Summit called on states to provide precise and detailed statistical data encapsulating all these components. Furthermore, a detailed timetable for the reduction of infant mortality rates was agreed upon:

> Countries should strive to reduce their infant and under five mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000, with appropriate adaptation to the particular situation of each country;
>
> By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 and an under five mortality rate below 60 deaths per 1,000;
> By 2015 all countries should aim to achieve an infant mortality rate below 35 per 1,000. Countries that achieve these levels earlier should strive to lower them further.[69]

These figures were again approved at the UN Conference on Women, Beijing, 1995, with the additional proposals that countries take specific measures to close the gender gaps in morbidity and mortality where girls are disadvantaged; and by the year 2015 not only should the infant mortality rate be below 35 per 1,000 live births but there should be an under-five mortality rate below 45 per 1,000.[70]

This approach to infant and child mortality illustrates an innovative approach to the establishment of goals in health. A fundamental minimum is established of between 50 and 70 per 1,000 live births initially but there is also flexibility and incremental staging to allow for regional adaptations as necessary. At the same time, the ideal of the 'highest attainable standard of physical and mental health' established in Article 12 of the ICESCR is not undermined. This obligation to reduce infant mortality is viewed as being not only the responsibility of the individual state within its boundaries but of the international community,[71] NGOs and

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Process or conduct indicators refer to processes, structures and activities undertaken.
[68] Full text available at http://www.iisd.ca/linkages/Cairo/program/p04001.html - 1/19/99.
[69] See section 8.16.
[70] Document from the UN Conference on Women, Beijing, 1995, Article 107 (l). Using text found at http://www.iisd.ca/linkages 4wcw/dpa-028.html - 1/21/99.
[71] States with a reasonable domestic rate of infant mortality under these criteria still have an obligation to assist other states through the provision of financial and technical resources.

individuals.[72] However, without the development of corresponding process indicators, there is little direction for concerned parties and it is, therefore, more difficult to determine if the policy adopted is in conformity with human rights standards.

Maternal mortality

To reduce ill health and maternal morbidity the agreed-upon goal of both the Cairo Summit on Population and Development and the Beijing Conference on Women was to reduce world-wide maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015. [73] At the Cairo Summit there was again recognition that the realisation of these goals would have different implications for countries with different 1990 levels of maternal mortality. Therefore:

> countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100, 000 live births and by the year 2015 a maternal mortality rate below 60 per 100, 000 live births; while countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births. Moreover, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Also, disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed.[74]

The clear goals established for maternal mortality use the same formula as discussed above in relation to infant mortality. Again, there is an implicit fundamental minimum standard with the necessary flexibility and time allocation for states to adapt as necessary without supplanting the ideal standard. Some consider implementation of the UN guidelines as process indicators, would be a more effective way of monitoring and reducing maternal mortality than total dependence on impact indicators.[75] Health care services are an essential component of this process and there is a need to face the reality of how improvement in statistics is to be effected unless one considers it sufficient for states to obviate their obligations by being less efficient in the collection of data.[76]

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[72] Parents have responsibilities and obligations to their child as well. It is the duty of the state to provide the education and facilities to empower parents to exercise these obligations positively.
[73] See Article 107(i) of the document from the UN Conference on Women, Beijing, 1995.
[74] Cairo Summit on Population and Development, Article 8.21.
[75] The UN Guidelines referred to are those issued jointly by UNICEF, WHO and UNFPA in 1997 [developed by staff at Columbia University and UNICEF and outlined in Maine, D. *et al* (2nd. Ed.)(1997): Guidelines for monitoring the availability and use of obstetric services.] set minimum and maximum acceptable standards and are thereby "not only go a long way toward establishing which are the appropriate "strategies [for progress to be made] in reducing maternal mortality and morbidity," they can be used to monitor states' progress in combating maternal mortality as a matter of international human rights law" (p.607).
[76] Yamin and Maine (1999), p.594.

Infant immunisation

The World Summit for Children endorsed the joint WHO/UNICEF health goals for immunisation programmes in the 1990s are as follows:

> 1) Maintenance of a high level of immunisation coverage (at least 90% of children under one year of age by the year 2000) against diphtheria, pertussis, measles, poliomyelitis, and tuberculosis and against tetanus for women of childbearing age;
> 2) By 1995, reduction by 95% of measles deaths and reduction by 90% of measles cases compared to pre-immunisation levels as a major step towards the eventual global eradication of measles;
> 3) Elimination of neonatal tetanus by 1995; and
> 4) Global eradication of poliomyelitis by the year 2000.[77]

The goals established for childhood immunisation are high and would suggest a progressive trend towards eradication (the necessary outcome if the highest attainable standard of health is the ultimate goal). Unfortunately, there is no requirement for the collection of statistics to be disaggregated by geography, ethnicity or sex but these could be useful impact indicators ensuring a level of contact between health care professionals and children is made in their first year of life. Use of such public health statistics alone, however, provides limited information on the health of the community been addressed.

Life expectancy

Article 8.5 of the programme of action from the Cairo Summit advocates that countries:

> should aim to achieve by 2005 a life expectancy at birth greater than 70 years and by 2015 a life expectancy at birth greater than 75 years. Countries with the highest levels of mortality should aim to achieve by 2005 a life expectancy at birth greater than 65 years and by 2015 a life expectancy at birth greater than 70 years. Efforts to ensure a longer and healthier life for all should emphasise the reduction of morbidity and mortality differentials between males and females as well as among geographic regions, social classes and indigenous and ethnic groups.

It is interesting that, when considering the issue of life expectancy, the Summit adopted a statistical minimum approach. From a human rights perspective, I think it is important that statistics such as these are not over emphasised. Focusing on life expectancy leads to advocating a utilitarian approach to health care. States will naturally focus on major causes of death. I do not believe that this is the only way to decide priorities that enhance the right to health. Certainly, for some states attention would thereby be focused on

[77] Tarimo, E. & Webster, E. (1997): Primary health care concepts and challenges in a changing world: Alma-Ata revisited, pp.44-45.

the availability of sufficient food and clean water[78] whereas for other states the focus would be directed at social habits such as tobacco. However, quality of life also needs to be an important consideration.

Generally, however, the approach adopted at these various UN conferences illustrates that it is possible, in some areas at least, to require states to reach precise statistical levels of attainment to ensure progress towards the highest attainable standard of health. With such data it should, therefore, be possible to begin to monitor and evaluate states compliance with its obligations under the right to health. All the indicators described above, however, are very general in nature and were not specifically designed to monitor the right to health. Sole dependence on global impact indicators would also be unacceptably limited. But this global consensus has certainly had great influence on the most recent WHO's global targets, although to some extent these targets are less specific than the goals discussed above.[79]

The WHO's global targets are set out in Health for All in the Twenty First Century, A51/5.[80] They are the following:

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[78] Most of the international conferences have considered the need for basic water and sanitation as inter-linked issues that have consequently been addressed together. To date no specific indicators or targets have been established in relation to individual or community access to water and sanitation.
At the UN Conference on Environment and Development, 1992, a blueprint for sustainable development was endorsed in the form of *Agenda 21*. In relation to water supply and sanitation the Dublin Principles were endorsed as the appropriate general direction for international focus. The Dublin Principles state:

- Freshwater is a finite and vulnerable resource, essential to sustain life, development, and the environment.
- Water development and management should be based on a participatory approach, involving users, planners and policy-makers at all levels.
- Women play a central part in the provision, management and safeguarding of water.
- Water has an economic value in all its competing uses and should be recognised as an economic good.

At the latest meeting of the Commission on Sustainable Development (CSD6) the need for urgent action to enable the unserved poor to gain access to basic water and sanitation services was re-emphasised and the use of strategies based on integrated water resources management re-affirmed. The need for participatory approaches, gender sensitivity, and the integration of water projects into national water strategies was also reinforced. The World Food Summit, 1996, in its plan of action stressed the role of water in food security as well as poverty alleviation.

[79] This approach suggests a growing awareness and integration with the wider international community and is a new development for the WHO. Note that the maternal mortality rates, under five and child mortality rates and life expectancy rates discussed above have been expressly included in the WHO's targets.

[80] 51st World Health Assembly, May 1998, Official Report WHA51/5, 'Contract of the Director-General,' para.38.
Fuller discussion of Health for All in the Twenty First Century is to be found in chapter 4.

## A. Health outcomes

1. By 2005, **health equity indices** will be used within and between countries as a basis for promoting and monitoring equity in health. Initially, equity will be assessed on the basis of a measure of child growth.[81]
2. By 2020, the targets agreed at world conferences for **maternal mortality rates** (MMR), **under-five** or **child mortality rates** (CMR), and **life expectancy** will be met.
3. By 2020, the **worldwide burden of disease will be substantially decreased.** This will be achieved by implementation of sound disease-control programmes aimed at reversing the current trends of increasing incidence and disability caused by tuberculosis, HIV/AIDS, malaria, tobacco-related diseases and violence/trauma.[82]
4. Measles will be eradicated by 2020; lyphatic filariasis will be eliminated by the year 2020; transmission of Chagas disease will be interrupted by 2010; leprosy will be eliminated by 2010; and trachoma will be eliminated by 2020. In addition, vitamin A and iodine deficiencies will be eliminated before 2020.[83]

## B. Intersectoral action on the determinants of health

5. By 2020, all countries, through intersectoral action, will have made major progress in making available safe **drinking-water**, adequate **sanitation**, **food** and **shelter** in sufficient quantity and quality.
6. By 2020, all countries will have introduced, and be actively managing and monitoring, strategies that **strengthen health-enhancing lifestyles** and **weaken health-damaging ones**, through a combination of regulatory, economic, educational, organizational and community-based programmes.[84]

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[81] No further indication is given as to the nature or format of such health equity indices except that implementation is to take effect by 2005. In the meantime, the equity assessment is to be based on the percentage of children under five years who are stunted (defined as height-for-age more than two standard deviations below the reference value). The target is that less than 20% of children in all countries and in all specific subgroups within countries should be so categorised by the year 2020.
[51st World Health Assembly, May 1998, Official Report WHA 51/5, 'Contract of the Director-General,' p.46].

[82] This approach is more suggestive of a vertical medical model than a holistic approach to health.

[83] Suggesting that there is still a strong penchant towards vertical disease eradication.

**C. Health policies and systems**

7. By 2005, all Member States will have operational mechanisms for developing, implementing and monitoring policies that are **consistent with this HFA policy**.
8. By 2010, all people will have **access** throughout their lives to **comprehensive, essential, quality health care, supported by essential public health functions.**
9. By 2010, appropriate global and national health information, **surveillance and alert systems** will be established.
10. By 2010, **research policies** and institutional mechanisms will be operational at global, regional and country level.

These targets, as important as they are, remain firmly based on a public health model and leave many gaps when considered in relation to the right to health. The approach so far advocated fails to consider how to monitor and assess the impact of policy on individual rights, community rights and international obligations. However, even in terms of developing indicators to monitor and assess state actions to give effect to its obligations there is clearly a great deal more work to be done. Presumably, it is indicators developed to monitor progress towards achievement of these targets that is being advocated and adopted in relation to the right to health.[85] Unfortunately, if this is the case the emphasis will remain heavily in favour of impact indicators even though there is clearly a need for process or conduct indicators[86] and precondition indicators as well.[87]

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[84] Again, suggestive of the latest approach adopted by the World Bank. While there is understandable merit and utility in this target, it can lead to unreasonable scapegoating and isolation of individuals.

[85] General Comment No. 14 of the Committee on Economic, Social and Cultural Rights in paragraph 57 advocated adoption of national and international indicators based on the on-going work of WHO and UNICEF.
The revised list of global health indicators in relation to monitoring and evaluation processes on health systems is due to be published in the World Health Report later in 2001 but these indicators have been developed pre-dominantly by economists and so with minimal regard for human rights concepts or needs.

[86] This position was clearer in an earlier draft proposal on the right to health. Riedel's suggestion being that 'process or conduct indicators refer to processes, structures, and activities undertaken by States to ensure the inclusion of a human rights perspective in health policies and programmes. [Para.31 (b) of the draft general comment No. 14 (version of 23 March 2000) unpublished].
The examples given were unfortunately limited to the percentage of the gross national product spent on health (Para. 32 (10)) and the percentage of the national health expenditure devoted to local health care (Para.32 (11)).
Unfortunately, the examples he provides have limited utility. A great deal more work is needed to develop effective, relevant and specific process indicators.

[87] Precondition indicators relate to environmental and other underlying conditions necessary for the realisation of the right to health.

In addition, the Committee on Economic, Social and Cultural Rights is advocating adoption of indicators not specifically developed to monitor the right to health. It is clear that the international human rights community cannot rely on the WHO in its present form to provide the necessary direction. The WHO has its own agenda and currently has minimal comprehension of the goals of the right to health. As a result, the need for greater dialogue between the WHO, the Committee on Economic, Social and Cultural Rights and more human rights experts working directly with health professionals is essential. As will be discussed more fully below, the drafting of a Framework Convention on the Right to Health could be the catalyst needed to get these two isolated organisations focused on the same issues.[88]

The General Comment on the Right to Health adopted by the Committee on Economic, Social and Cultural Rights also advocates the development of 'appropriate national benchmarks,' which will than be 'scoped'[89] by the Committee in conjunction with the particular State party to provide specificity as to the obligation to be met by that State party within the next five year period. This raises the question whether states alone, without consultation with their people, should be allowed to establish these benchmarks and also be responsible for providing the data to support attainment of the agreed goals? Nevertheless, this proposal at least seeks to establish direction and priorities for State parties. In this regard, it goes further than the non-mandatory use of indicators adopted in relation to the Health-for-All programme.[90]

It is also important to note here that the right to health is more than the obligation established in Article 12 of the ICESCR. The WHO already has a much broader mandate in relation to the right to health and should act accordingly. Its role in the broader establishment of indicators would have an important impact in this regard. Useful work has already been undertaken by the UNDP in the development of project or

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Giving as examples population access to safe water in the home or within 15 minutes walking distance (Para. 32(12)) and population access to adequate excreta disposal facilities in the home or immediate vicinity (Para.32(13)).
[Riedel's draft general comment No. 14 (version of 23 March 2000) unpublished].

[88] One important benefit of the process of drafting the Framework Convention on Tobacco Control has been the open dialogue that it has precipitated. According to Bettcher (at the ASIL 2000 Conference – authors notes) all partners have recognised this as the greatest strength of the process to date.

[89] "Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period." [Paragraph 58 UN Committee on Economic, Social and Cultural Rights: General Comment 14].

[90] See chapter 4 for details.

community indicators that could be utilised by the WHO to protect and promote the right to health, particularly if undertaken in conjunction with greater local and regional community participation.[91]

iv) *Monitoring and evaluation systems*

There is no single blueprint, which if adopted, would give full effect to the right to health. Society's understanding and needs in relation to the right to health are in a constant process of evolution and this quality will only be exaggerated further if the WHO seeks to facilitate the social dialectic in relation to health. Therefore, an essential function of the WHO will necessarily be to establish systems that assess and evaluate internal and international programmes. Such a function would have close correlation with the development and analysis of indicators. Effective critique and the ability to be self-effacing would be essential if the right to health is to develop to meet the needs of society and the individual. This will require teamwork. While the WHO may be a key player, it alone cannot be the sole arbiter or protector of the right to health. It is a collective responsibility and obligation and so should be managed as such. To further facilitate established enforcement and monitoring systems it may become appropriate, at some point, for the WHO to develop alternative dispute resolution mechanisms for this purpose.

**2) <u>Within the United Nations system</u>**

i) *Co-ordinate communication*

Adoption of the right to health by the WHO provides it with a mandate and particular perspective in relation to health that would necessarily impact on its relations with other international organisations. In order to protect its position as the key player in the development of the right to health, the WHO must be prepared to take a stance, both pro and con, on health issues or actions adopted by other international agencies. Early, effective dialogue is essential to avoid the necessity of confrontation. This, however,

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[91] The paper by Green for the UNDP entitled 'What we talk about when we talk about indicators: current approaches to human rights measurement' provides a useful overview on the subject and is particularly useful when read in conjunction with another of UNDP's papers: 'Sustainable livelihoods: concepts, principles and approaches to indicator development'.
[http://www.undp.org/sl/Documents/Indicators, 12/16/1999].
The sustainable livelihood approach attempts to "balance concerns of social equity, ecological security and economic integrity" at different levels of activity (local, national and global) as it seeks to "make development interventions participatory and holistic" (p.21).
Such an approach could perhaps be adapted to ensure health policy initiatives at all levels are also more participatory and holistic.

requires a close working relationship with other organisations and the determination by all parties to engage in effective communication.

ii) *Health impact assessment*

As part of its initiative in relation to health and poverty, the WHO is seeking to ensure pre-emptive health impact assessments become an integral part of policy planning by all UN institutions to ensure that health is not inadvertently compromised. The ability to assess and monitor sustainable development projects is also an important tool that the WHO can use to protect the right to health. Perhaps, the model developed to do this can also be modified for states to use as they develop policy in this area.

iii) *Partnership*

Partnership with other concerned organisations and institutions is an essential method to protect the right to health. In addition to facilitating improvements through communication and specific intervention in the form of impact assessments, the WHO must play a significant role in protecting and enforcing the right to health by providing expansive reports to the appropriate enforcement bodies. A general report on a state's actions in relation to the right to health is of invaluable assistance not only to the Committee on Economic, Social and Cultural Rights but also regional human rights bodies and specialised human rights bodies concerned with particular aspects of the right to health. Specific reports must be directed to assist the functioning of the Security Council, the proposed International Criminal Court, war crimes tribunals and agencies such as the WTO. But these reports can only be comprehensive when written in collaboration with other relevant UN agencies.[92]

Close collaboration with the Committee on Economic, Social and Cultural Rights and other pertinent human rights bodies is essential to ensure a measure of accountability and consensus as to the appropriate direction for the right to health. Institutionalisation of the right to health by the WHO, if done in isolation, can inadvertently have a negative effect on the rights it is seeking to protect. Failure to comprehend human rights principles or translate them correctly into policy could have the unfortunate effect of sabotaging the

[92] Such a partnership approach would facilitate the effective distribution of information throughout the UN system. In so doing, the WHO would also be establishing itself as an important resource for the whole UN system and beyond.

right to health. Care must be taken to ensure that residual internal habits of the WHO do not deflect or misinterpret the human rights ideals it is striving to implement.[93]

Obviously, all the tools available to the WHO to enhance protection and enforcement of the right to health are inter-linked regardless of whether they are directed specifically at state or UN institutions. The key to co-operation is clarity of understanding and approach. For this, the development of indicators is essential. As I have repeatedly emphasised, the WHO is ideally placed to act as the intersection for human rights ideals and principles and practical health policy in order to give effect to the right to health.

**D. An Academy of Health – a proposed outline for such a body**

At the International Health Conference, 1946, the Brazilian delegate proposed the inclusion of an advisory council of health experts as one of the principle organs of the WHO. The idea was that such a council would keep the organisation from becoming too 'bureaucratic' and could gradually develop into an international academy of health.[94] The Technical Preparatory Committee, however, felt that the organisation would have the constitutional power to set up such a committee should it later be considered appropriate and explicit provision for such an eventuality was not considered necessary.[95] This option has, unfortunately, not been officially discussed or considered since. However, were the WHO to embrace human rights ideology, particularly the right to health, as I would advocate, establishment of an Academy of Health would be invaluable. It could also prove to be an extremely useful mechanism for improving the accountability of the Director-General and the Secretariat as well as ensuring consistency of policy. To achieve this, it would be essential that the Academy of Health be permanently constituted. As suggested at the original Technical Conference, establishment of such a body would require minimal or no amendment to the current Constitution as the WHA and the Director-General have the power to establish such

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[93] Professional identity remains strongly attached to the medical model and there has to be some restriction on the action of the Director-General to avoid misinterpreting or misappropriating the key principles encapsulating the right to health.

[94] Proceedings and final acts of the International Health Conference, 1946, Official Records No.2, part III summary report of proceedings p.19.

[95] Ibid.

Certainly, an interesting precedent has recently been set in this regard, for as part of the discussion concerning the formation of institutions under the Framework Convention on Tobacco Control the notion of a permanent body has been considered.

[First meeting of the working group on the WHO Framework Convention on Tobacco Control, September 1999,Official Records A/FCTC/WG1/6, 'Elements of a WHO framework convention on tobacco control,' Box 5, p.25.]

committees as are considered appropriate.[96] The position and authority of such a body would, however, be considerably strengthened if it were to be formally established under a Framework Convention on the Right to Health.[97]

The Academy of Health, I envisage, would consist of two closely connected branches. The first would be a co-ordinating body predominantly concerned with co-ordination of policy while the second, an academic body, would focus more on academic research concerned with developing the right to health. The personnel would have a broad interest in health but a medical background would certainly not be essential. Indeed, efforts should be made to attract staff from a range of disciplines such as anthropology, philosophy, economics, social sciences and international law. Of course, such a body would work closely with the Secretariat and the Director-General but not under the existing 'Regulations for Expert and Advisory Panels and Committees', as this would be too restrictive an approach and would give the Director-General inappropriately wide discretionary power over the Academy of Health.[98]

**1) Co-ordinating Body**

Part of the remit of the Co-ordinating Body would be to ensure that all the programmes instigated by the WHO were consistent with or furthered the right to health. This would ensure that human rights and particularly the right to health were an integral and essential element of the work of the organisation. Once firmly established within the WHO, this body could perform a similar function within the broader UN system. It would not only co-ordinate policy with other international organisations concerned with particular aspects of health, but also seek to ensure that all health policy was compatible with the right to health, ensure due consideration of the human rights implications of policy and undertake health risk assessments of proposed international policy. This would require development of a much closer working relationship with ECOSOC as well as the Committee on Social, Economic and Cultural Rights. Broader avenues of interaction would be necessary than were provided for the current WHO/UNICEF/UNFPA co-

[96] WHA has authority under Article 18(e) and the Director-General under Article 38 of the Constitution of the WHO (reproduced in AnnexI).
[97] The feasiblity and implications of a Framework Convention on the Right to Health will be discussed in detail later in this chapter.
[98] For details of the 'Regulations for Expert Advisory Panels and Committees' see Basic Documents (42nd ed.), (1999), pp.98-106.

ordinating committee on health.[99] While this group may form the core institutions concerned with effecting the right to health there are also organisations such as UNDP and the World Bank who initiate policy that could impact directly on the right to health. In addition, there are a host of other organisations with a less direct and/or more specific effect on the right to health.[100] Similarly, academic institutions and relevant non-governmental organisations should also have a voice, as should the regional offices and local communities. It may be appropriate to bring all these under the umbrella of this body as well but with variable levels of involvement and power.[101]

2) Academic body

This branch of the Academy of Health would benefit from working closely with the co-ordinating body to ensure consistency of approach but would mainly be concerned with developing and promoting the right to health. It would conduct academic research on the right to health, while also working closely with other academic institutions such as the Francois-Xavier Bagnoud Center for Health and Human Rights and the Council for International Organisations of Medical Science. Its remit would be to establish normative standards for health in the form of draft treaties, regulations or recommendations. This academic body would then be responsible for monitoring compliance with these normative standards and would write and publish critical reports outlining its findings. To ensure conformity with the Constitution, it would be for the WHA to then address the issues raised by the academic body unless other provisions were made in the respective treaties. This academic body should have the power to analyse and critique reports provided by Member States either in conformity with Article 61 of the WHO's Constitution[102] or under Article 16 of the ICESCR. The various treaty bodies monitoring compliance with the right to health could then make use of such analysed reports.[103]

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[99] Further details on the terms of reference of WHO/UNICEF/UNFPA committee see Executive Board, 103rd session, January 1999, Official Report EB103.R17, 'WHO/UNICEF/UNFPA coordinating committee on health: terms of reference,' Annex 1.

[100] For example: UNESCO, FAO, WFP, UN High Commission for Refugees, ILO, UN Environmental Programme and the UN Fund for Drug Abuse Control.

[101] Perhaps, a model can be developed that is similar in approach to the ILO. Representation on the Governing Body of the ILO is open to government representatives but also representatives of employers and workers. See Article 7 of the ILO Constitution, [reproduced at http://www.ilo.org/public/english/about/iloconst.htm].

[102] Greater pressure would need to be placed on Member States to produce a detailed report.

[103] As discussed in chapter 2.

In order to obtain accurate information and thereby protect the right to health such a body cannot rely solely on information provided by states. It should also have the power to consider information provided by individuals, non-governmental organisations or community petitions as appropriate to gain a more rounded perspective. The WHO's regional structure could be utilised to function as a conduit to ensure input from regional and local communities. Statistical data collected by the Secretariat, based on indicators seeking to monitor the right to health, would be another essential component.

As the system develops especially once directly effective regulations and treaty obligations come into force, it may become appropriate for the Academy of Health to have the power to hold hearings. These could be loosely based on the structure of such bodies as the ECJ, the WTO or the European Court of Human Rights. Such an approach may become particularly useful to monitor specific issues such as cloning, genetic manipulation, pharmaceuticals and the proposed Framework Convention on Tobacco Control.[104] Throughout, the emphasis would be to seek to ensure conformity with the right to health. Such a process would clearly benefit from having a Framework Convention on the Right to Health to consolidate ideas and provide the necessary driving force.

While this may seem to be a very idealistic picture of an international body, generally within the field of health there is a greater measure of consensus and an undeniable globalisation of issues that may allow such a body to develop. As a greater understanding and a more coherent international approach is developed for protection of the right to health then this approach is more likely to gain world-wide acceptance. Furthermore, it should be aided greatly by the experience gained in the drafting of a Framework Convention on Tobacco Control.

### E. A Framework Convention on the Right to Health

#### 1. Do we need a Framework Convention on the Right to Health?

Establishing a Framework Convention on the Right to Health would raise the profile of health. It would signify that health is a fundamental human right that is valued within society. I believe that the value and importance of health needs to be formally established. Health is an indispensable element of life and

[104] As discussed in chapter 7.

pivotal to one's ability to enjoy many of the other articulated human rights, it should be recognised as being worthy of protection and promotion.

The General Comment on the Right to Health adopted by the Committee on Economic, Social and Cultural Rights was an important first step but, as was established in chapter 3, was only the beginning for the conceptualisation of the right and the outlining of legal obligations. There remain many substantive issues that need to be addressed. Some of the clarification issues are well within the scope of the ICESCR and will probably become clearer through the jurisprudence it develops but other issues are beyond the scope of the ICESCR. The underlying determinants of health, for example, have impact beyond the scope of the ICESCR or any other single treaty currently in force. In addition, the Committee on Economic, Social and Cultural Rights does not have the time, resources or expertise to effectively monitor, develop and enforce the right to health. A system is needed that brings together human rights experts with health professionals in a formal arrangement. Globalisation and recent developments in medical technology are only some of the growing range of health issues that need to be addressed at the global level increasing the need to establish a system by which a collective approach and decision-making process can be facilitated.

The General Comment on the Right to Health also created an exciting momentum and enthusiasm among bodies concerned with international health issues that needs to be reinforced before it dissipates and the potential energy and focus is lost. The process of drafting such a Framework Convention can precipitate open inclusive dialogue that in itself can be invaluable to the development and internalisation of the right to health. However, to achieve this, the debate needs to reach beyond academics and human rights bodies to include health professionals and ordinary people especially as rationing of health services is a reality, but allocating resources to comply with human rights standards needs to be a matter of social choice.[105]

A Framework Convention on the Right to Health and its accompanying protocols would also establish further legal obligations in relation to the right. It could build on and consolidate the legal obligations established under the ICESCR. Particularly important is the need to clarify the legal obligations, rights, duties and responsibilities of non-state actors. All parties to the treaty would adopt a system of mandatory indicators and benchmarks as well as a health impact assessment model to ensure conformity and

uniformity of approach. A global approach to monitoring and evaluating the right to health is an essential component of developing and protecting the right.

## 2. Essential pre-conditions

A great deal of work still needs to be done before it is feasible to consider even attempting to draft a Framework Convention on the Right to Health. There are three main pillars on which a framework convention would be based that need to be consolidated first. These are: the need to further conceptualise the right to health; the need to establish a system of broad consultation; and the need to develop the essential tools to monitor the right to health. Only when these essential elements have been firmly established and agreed upon will it be possible to consider the drafting of the Framework Convention on the Right to Health itself.

### i) *Further conceptualising the right to health*

Research is needed to more clearly identify the underlying determinants of health and to establish their level of impact on health. At the moment, it is difficult to establish a system to protect and promote the right to health when the concept of underlying determinants is so undefined as to be completely nebulous. More research is needed to try to categorise the various components so as to be able to establish a more integrated approach. The impact of social and political structures on health is one aspect of the underlying component of this categorisation on the right to health that certainly needs to be more clearly understood. This is work that can be done by the academic body of an Academy of Health.

### ii) *A system of broad consultation*

Prior to the drafting of a Framework Convention on the Right to Health, there would need to be broad consultation on the various elements of the right to health and how they could best be promoted and protected. This would be a huge undertaking that would take time, energy and resources. At present, there is no structure in place to enable such a process to occur and there would need to be a massive education programme to facilitate participation.

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[105] Molinari (1998), pp.41-60, p.53; and Morrow and Bryant (1994), p.56.

The level of participation essential for the development and fulfilment of the right to health is heavily dependent on having a well-informed constituency.[106] Attainment of the necessary level of education and the free flow of information would be an obligation on the international community as a whole. Some issues are context sensitive and should reflect local values with specific legal rules and remedies to protect individual and collective rights. Other issues are broader in impact and therefore become the concern of the global community. Hence, the need for co-operation, dialogue and informed debate exists at all levels of a democratic, flexible international framework. When considering the right to health at the domestic level, there will invariably be a broad range of multicultural styles and politics. Implementation would require international monitoring that can recognise, facilitate and accommodate this process, while retaining an impartial stance based on the global fundamental concept of the right to health.

There is no existing structure that enables dialogue and negotiation to occur at all levels of society. Such a system would need to be established building on existing institutional frameworks, but the process would need to have a greater level of openness and accountability than currently exists at the international level if it is to be accepted as a legitimate process by society as a whole. There also needs to be a clearly identified process to effectively integrate the various proposals into a single document. The WHO is probably in the best positioned to develop such a process.

iii) *Essential tools to monitor the right to health*

There is clearly a need to develop indicators, benchmarks and health impact assessment models by which it will be possible to effectively monitor and evaluate progress towards fulfilling obligations in relation to the right to health. Such tools will need to be tested and universally accepted as effective before they can be legitimately implemented. All this takes time. Now at least the basic components of the right to health have been identified and so the development of such tools is at least feasible. However, it is difficult to envisage the development of such tools until there is a greater understanding of the right to health than currently exists among economists, social scientists, health professionals, ethicists and politicians. The WHO is well placed to facilitate this process.

[106] Lee, K. (1998): 'Shaping the future of global health cooperation: where can we go from here?' Vol.351 Lancet, pp.899-902, p.902.

### 3. Structure

Since the Framework Convention on the Right to Health could only occur at the end of all the work noted above, it would have to be viewed as a very long-term objective. Another option would be to base the Framework Convention on the General Comment as adopted by the Committee on Economic, Social and Cultural Rights. Such an approach would raise the profile of the right to health and facilitate the dialogue that began with the drafting of the General Comment on the Right to Health. But in many ways it would be a waste of an opportunity. The limitations that were identified in chapter 3 would still apply and the tools would not be available to further develop the right to health. Because the General Comment on the Right to Health clearly established legal obligations on states that can be monitored by the Committee on Economic, Social and Cultural Rights, there is another possible compromise option that could be considered based on the tripartite approach to human rights. A three-part framework treaty convention could be developed based on the obligations to promote, protect and fulfil the right to health. In the interim, the Committee on Economic, Social and Cultural Rights would continue to monitor and enforce the existing legal obligations under the right to health in the ICESCR and the WHO could begin the process of adopting the right to health as its core principle.

**Treaty One – The Right to Health and the Obligation to Respect the Right**

- Preamble establishing the importance of the right to health and the intention to develop a three-part inter-connected treaty.
- Develop the normative content of the right to health with the identification of the right to health care, socio-economic factors impacting health and the underlying determinants of health. With the highest attainable standard of health as the overall objective.
- Focus of this treaty will be on the legal obligation to respect the right to health

  As this relates to:

  States

  International Organisations

  Multinational Organisations

  Non-Governmental Organisations

  Communities

  Individuals

- Identify clear violations of the right to health
- Identify rights of local communities and individuals in relation to the right to health.

  Establish an international project to improve access to education and information on the right to health, issues of interest and public participation.
- Establish a system to begin the process of broad consultation on the right to health.

**Treaty Two – The Right to Health and the Obligation to Protect the Right**

- Establish core obligations in relation to the right to health.
- Establish the obligation to protect the right to health on the part of states and non-state actors.
- Identify the Health Impact Assessment Model to be used.
- Clarify the categorisation of the underlying determinants of health.
- Adopt a system to monitor, promote and protect the right to health
  - It should build on the approach developed in the Framework Convention on Tobacco Control to minimise overlap.
  - It should include a system for dispute resolution
  - It should provide for the right of petition of individuals, community and NGO's at the international level.
  - It should integrate domestic and international systems of enforcement.
- Treaty Two should establish the possibility of attaching appropriate protocols and annexes to utilise the same system of enforcement and dispute resolution. These should include:
  - **Regional Protocols** that build on the basic right to health to establish regional approaches, issues and needs.[107]
  - **Local Annexes** that represent local agreements, approaches and processes and

[107] The United Nations Convention to Combat Desertification in those countries experiencing Serious Drought and/or Desertification, particularly in Africa, 12 September 1994. A/AC.241/27, entered into force 26 December 1996 and it allows for regional implementation annexes.
It has four regional implementation annexes concerned with Africa, Asia, Latin America and the Caribbean and the Northern Mediterranean.
According to Article 15 of this Convention:

> "Elements for incorporation in action programmes shall be selected and adapted to the socio-economic, geographical and climatic factors applicable to affected country Parties or regions, as well as to their level of development."

could include such items as a Local Patient's Charter.

- **Subject Protocols** that concern one specific subject or group in relation to the Right to Health such as:
    - A Charter of Welfare Rights
    - Reproduction Rights
    - HIV/AIDS
    - Access to Pharmaceuticals
    - Medical Technological Advances
    - Mental Illness
- **Regulations** and **Recommendations** to outline specific technical details.

**Treaty Three – The Right to Health and the Obligation to Fulfil the Right**

- Establish legal obligations to fulfil the right to health in relation to state and non-state actors
- Agree on a mandatory system of indicators and benchmarks to be used to monitor progress towards respecting, protecting and fulfilling the right to health to be integrated into the enforcement system established in treaty two.
- Use of regulations and recommendations to provide the technical detail.

The advantages of adopting such a system is that a dynamic process is established that can be evaluated and adapted over time. It encourages an extended dialogue and enables the process of drafting a framework convention to begin before all the essential elements have been developed. The end result, however, should be a comprehensive and integrated system that establishes clear obligations on all parties and an effective system for monitoring, promoting and protecting the right to health. The complexity of the task, however, would be immense and would be dependent on political will to maintain the momentum. An Academy of Health would be an essential institution to act as the administrative body for the process and to facilitate the process over an extended period of time.

**F. Conclusion**

With minimal upheaval, the WHO has the capability to act as an important advocate, protector and enforcer of the right to health. By so doing, it would gain the focus and direction that it currently lacks and become the essential key to the continued development of the right to health. In the long term, an Academy of Health should be considered to facilitate this process more effectively. The drafting of a Framework Convention on the Right to Health is a difficult and formidable task but the process alone has the potential to have a profound effect on the understanding, needs and responsibilities in relation to health of all sections of the population. The conceptualisation of the right to health and the accompanying establishment of a broad spectrum of legal obligations would be exciting and innovative in approach. Such a framework treaty would do much more than consolidate the position of the right to health but it is practically impossible to speculate on the revolutionary potential that could ensue.

# 9.

## Recommendations and Conclusions

In this thesis, I have considered the value of a stronger relationship between the WHO and the right to health. To this end, I have made a number of proposals that seek to ensure that the WHO gains optimum value from this relationship, while being equally concerned to ensure the integrity and practical development of the right to health. These recommendations impact on the structure, policy and external relations of the WHO and should be considered as a whole, while recognising that there would still be value if a selective approach were adopted.

### A. Recommendations

#### 1) Structure

The WHO should seek to utilise more effectively the progressive structure, with which it was originally provided, to form a more integrated system. There are a number of recommendations made in this thesis that seek to reform the current system to facilitate such an outcome. Listed below, from the most likely to the least likely, are structural changes to be adopted by the WHO. These are:

- The WHO should better utilise its standing as a UN specialised agency. The organisation was established as the primary institution within the UN system concerned with health. It should seek to re-assert this position and use advocacy of the right to health as its mandate to direct its relations with the other UN institutions.

- The WHO should be recruiting a broader range of expertise, beyond its normal range of health professionals, including international lawyers, domestic lawyers, human rights experts, social development experts, anthropologists and philosophers. Such expertise would work on projects aimed at developing and promoting the right to health.

- The WHO should amend and expand the scope of Article 21 of the Constitution to allow the WHO to issue regulations critical to the implementation of the right to health.

- The WHO should undertake essential reform of its existing decentralised structure, allowing it to act as a conduit for dialogue that would facilitate discussion at all levels from local communities to the state, to the regional and also to the international level. This would require the Regional Offices and Country Representatives to focus beyond the various Health Ministries so as to establish relationships with grassroots non-governmental organisations and local communities.

- The WHO should establish a permanent Academy of Health with two inter-related bodies: 1) a co-ordinating body to ensure internal programmes are consistent with or further the right to health and assess the policy of other international organisations to ensure similar compatibility, and 2) an academic body to develop and promote the right to health and with the potential to establish dispute resolution mechanisms as deemed appropriate.

Most of these recommendations could be adopted with minimal constitutional amendment.
The intent of all of these structural changes is to promote broader participation and a free flow of information. These are the essential elements to creating an exciting and more versatile system.

2) Policy

The recommendations made in relation to policy are based on the hypothesis that the WHO will adopt the right to health as its principle mandate. The recommendations are listed from the most important to the least important policy to be adopted by the WHO. The recommendations in this area are:

- The WHO should return to its original mandate as established in its Constitution. This mandate still remains pertinent today and would require the WHO to adopt the right to health as its over-arching philosophy or core principle. This would necessitate the development of consistent crosscutting policy and direction based on fundamental human rights principles and concepts.

- The WHO should view its Health-for-All initiative as a starting point and build on its experience to develop indicators to facilitate achieving the 'highest standard of health'. In developing these indicators, the WHO should develop a closer working relationship with the various human rights treaty bodies and academic experts in the field of human rights.

- The WHO should establish a much more proactive relationship with human right treaty bodies. This would require the WHO to evaluate state reports submitted to the various human rights committees regarding the right to health and provide a comprehensive and analytical report based on the state report and its own data collection and analysis. The WHO would then be in the position to support and monitor the implementation of health policy on a permanent basis to facilitate states in meeting their obligations under the right to health. It should consider the adoption of other enforcement mechanisms to enhance protection already available under existing treaty based obligations and also assist states to develop their own national enforcement mechanisms.

- As the key advocate for the right to health, the WHO should make greater use of its legal powers to establish normative international standards. It has gained international recognition for its technical recommendations but should build on its experience as instigators of a Framework Convention on Tobacco Control to develop an integrated international legal system that utilises not only its powers to draft treaties but also incorporates, where appropriate, regulations and recommendations to advance the right to health.

- The WHO should initiate the drafting of a Framework Convention on the Right to Health with broad consultation that includes regional and community participation, - and allows for the attachment of regional protocols and local annexes as well as the more detailed protocols relating to specific elements of the general right. An outline of the approach I recommend for the drafting of a Framework Convention on the Right to Health is to be found in chapter 8.E (3) and a draft version of Treaty One (The Right to Health and the Obligation to Respect the Right) is detailed in Annex III.

- Assuming that the WHO achieves expansion of the scope of Article 21, the WHO should begin to use the approach of issuing regulations to implement the right to health. For example, regulations could then be used in conjunction with Treaty Two (The Right to Health and the Obligation to Protect the Right) as outlined in chapter 8.E (3).

**3) Relationship to third parties:**

The WHO should be concerned to broaden its range of partners so as to become a key player in relation to the right to health. The recommendations are listed from the most likely to the least likely undertakings of the WHO to achieve this goal. The recommendations in this area are:

i) Relationship to other international organisations:

- The WHO should assert leadership in health issues among other international organisations by acting as primary advocate for the right to health.

- The WHO should ensure its policy and that of other international organisations is in conformity with human rights standards in regard to health. To accomplish this, the WHO should continue to actively co-operate and collaborate with other UN institutions, while critically analysing all projects undertaken by these institutions that impact on health. In particular, the WHO should further develop and implement broadly pre-emptive health impact assessments that protect the right to health.

- The WHO should encourage the standardised use of global health indicators concerned with monitoring the right to health throughout the UN system and facilitate the flow of information between the various organisations.

ii) Relationship to states:

- The WHO should use its long-standing relationship with the Ministers of Health to educate the states as to the concepts, principles and state obligations regarding human rights, particularly focusing on the right to health. Practical assistance should be rendered to states: 1) to assist in the implementation of pertinent policy and particularly legislation to enhance the right to health, 2) to develop national benchmarks against which state obligations can be monitored and assessed and 3) to encourage greater collaboration and recognition of inter-state obligations regarding the right to health.

- The WHO should monitor, support but also constructively criticise state policy dealing with the right to health by providing independent reports on activities of states in this area for use by human rights treaty bodies. Wherever possible, these reports should be based on the WHO's own data collection.

- The WHO should better utilise and support its Country Representatives to reach beyond state governments to grassroots non-governmental organisations, local communities and local government so as to facilitate dialogue and gain a greater understanding of localised needs regarding the right to health.

iii) Relationship to non-governmental organisations:

- The WHO should establish a closer working relationship with a broad range of non-governmental organisations dealing with issues of health and the right to health. Such a relationship should be established within an ethos of mutual respect and partnership and should seek to be less hierarchical in nature.

- The WHO should encourage a greater level of participation by non-governmental organisations at the annual meetings of the WHA and the various WHO committee meetings.

- The WHO should use non-governmental organisations to establish a connection with the grassroots community and thereby facilitate 1) local communities having a voice in the development of health strategies to promote and implement the right to health, 2) the monitoring of state action and the impact of state policy and 3) the developing of pertinent health information strategies.

iv) Relationship to multinational corporations:

Multinational corporations have a major impact on global health but, under traditional international law, they are not subject to human rights obligations except as such human rights obligations are implemented and enforced by the state in which the corporation is established. To improve this situation:

- The WHO should monitor the activities and impact of such corporations on the right to health and assist states to develop more effective methods of regulating activities of multinational corporations that adversely impact on the right to health.

- The WHO should collaborate more closely with trade organisations such as the WTO to ensure that the health implications of trade are sufficiently considered by multinational corporations.

- The WHO should encourage multinational corporations to participate in the development of normative standards regarding the right to health and their obligations in this regard.

- The WHO should establish a dialogue with the relevant corporations so as to educate them about health impact assessments and right to health principles.

v) Relationship to local communities:

Although local communities do not traditionally have *locus standi* at the international level, the impact of health on the local community is significant in relation to both health care and underlying preconditions for health. Many of the issues encompassed in the right to health reach beyond the individual and should be recognised as having this broader impact on the local community. To achieve more involvement by local communities:

- The WHO should recognise the rights of local community groups by 1) establishing formal and informal dialogue with them, 2) ensuring the widespread dissemination of pertinent information particularly in relation to legal rights to local communities, 3) encouraging broad based participation by local communities in the development of policies to be implemented regarding the right to health and 4) encouraging the drafting of regional and local health charters that can be annexed to a Framework Treaty on the Right to Health.

- The WHO should recognise that health has a value component that is dynamic and historically contingent. Within current society, human rights form an important part of the social dialectic and can thereby facilitate change. Therefore, the WHO, as advocate for the right to health, has a responsibility to facilitate this social process within local communities.

vi) Relationship to individuals:

The right to health provides legally enforceable rights that need to be protected so that the individual can maintain her/his health status, while also facilitating personal flourishing. To achieve this:

- The WHO should ensure an adequate level of education is available to every person. The WHO should ensure that information is disseminated to all sections of the community in a neutral manner sufficient to enable effective decision-making by individuals regarding their right to health.

- The WHO should facilitate methods of dialogue and participation so that individuals has a voice and value their role in the decision-making process of health care and its underlying preconditions.

- The WHO should assist states in providing effective judicial, administrative and bureaucratic mechanisms to which individuals can obtain recourse in order to protect their right to health.

**4) The further development and implementation of the Right to Health**

It is indisputable that there is a legally binding right to health. The General Comment No.14 by the Committee on Economic, Social and Cultural Rights is significant for conceptualising the right and clearly establishing legal obligations. However, to develop it further, the following is required:

- The WHO should articulate the view that the right to health is a fundamental human right that is derived simply by virtue of being human. As such, it is important not to focus on the treaty system alone to develop it as this would be to narrow the right unnecessarily. The WHO should have an important role in this regard because unlike the various treaty bodies established to protect economic and social rights it is not as restricted in its focus. The WHO should adopt the right to health to enable the right to reach its full potential.

- The WHO should make it clear in relation to states that there are obligations to respect, protect and fulfil the right to health as it relates to health care and underlying health conditions, as they are broadly understood.

- Now that the right to health is generally accepted and understood it is necessary for the WHO to develop greater specificity as to the right to health:

  1) The WHO must recognise that the right to health will stagnate unless there is a greater level of dialogue between human rights experts and health practitioners. Such interfacing of approaches can only occur effectively when there is a commonality of communication. Therefore, the WHO, human experts and health practitioners should actively seek to attain a higher level of understanding of each other through dialogue, education and a closer working relationship.

  2) The WHO should take the lead in drafting and pushing for adoption of a Framework Convention on the Right to Health to formalise the concept and to enable greater specificity by the incorporation of various protocols and annexes.

- The WHO should advocate for the approach that the principle mechanisms of enforcement should be developed at the national level in the form of legislative protection that can be initiated by individuals or the local community. The international enforcement mechanisms should only be used to compliment and enhance national protection and should allow individual or group petition where possible.

- The WHO has a symbiotic relationship with the right to health such that it is difficult to envision one surviving without the other. An essential recommendation is that the potential of this relationship be recognised by the WHO and the international community as soon as is practical in order for both the WHO and the Right to Health to attain their fullest potential.

**B. Conclusion**

Some may view these recommendations as idealistic but the WHO has been slowly moving in this direction even though to date it has been reluctant to recognise the right to health *per se*. In reality, my proposal will require minimal additional constitutional amendment or reform, which has not already been recommended to improve efficiency and efficacy within the WHO. In practice, what I am advocating for is an institutional shift in attitude and approach to health. Although this may be the most difficult element to achieve, the WHO no longer has the option to ignore the role of human rights in health. It is also becoming

clear with the globalisation of health that hierarchical medicine can have only limited utility. The global community together will be required to make important decisions regarding health that will greatly impact on individuals everywhere. How these decisions are made is as important as the conclusions themselves. For such decisions to have international legitimacy there will need to be greater institutional transparency and accountability than is currently exhibited. An important catalyst in this regard would be to ensure the effective flow of information to facilitate public participation in policy decisions. As I have emphasised numerous times, the WHO is in the best position to accomplish this.

The fact that improvement in health status is as dependent on reform of social, political and economic structures as on medical advancements needs to be acknowledged and acted upon. One effect of clearly establishing a health and human rights agenda for the WHO is that it serves to highlight the importance of health within society. Adoption of such an agenda by the WHO emphasises that striving to promote and protect these rights is important and is not a luxury that can be subsumed by other economic needs. The right to health is fundamental to the enjoyment of most other rights and its value needs to be recognised as such by the international community. The WHO could and should take up this mantel not only for its own self-preservation but to ensure for society the greatest possible level of health.

**Annex I**

## CONSTITUTION OF THE WORLD HEALTH ORGANIZATION 1

THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

ACCEPTING THESE PRINCIPLES, and for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency within the terms of Article 57 of the Charter of the United Nations.

### CHAPTER I - OBJECTIVE

#### Article 1

The objective of the World Health Organization (hereinafter called the Organization) shall he the attainment by all peoples of the highest possible level of health.

### CHAPTER II - FUNCTIONS

#### Article 2

In order to achieve its objective, the functions of the Organization shall be:

(a) to act as the directing and co-ordinating authority on international health work;

(b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate;

(c) to assist Governments, upon request, in strengthening health services;

(d) to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments;

(e) to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories;

(f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;

(g) to stimulate and advance work to eradicate epidemic, endemic and other diseases;

(h) to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries;

(i) to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene;

(j) to promote co-operation among scientific and professional groups which contribute to the advancement of health;

(k) to propose conventions, agreements and regulations, and make recommendation7s with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective;

(l) to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment;

(m) to foster activities in the field of mental health, especially those affecting the harmony of human relations;

(n) to promote and conduct research in the field of health;

(o) to promote improved standards of teaching and training in the health, medical and related professions;

(p) to study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security;

(q) to provide information, counsel and assistance in the field of health;

(r) to assist in developing an informed public opinion among all peoples on matters of health;

(s) to establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices;

(t) to standardize diagnostic procedures as necessary;

(u) to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products;

(v) generally to take all necessary action to attain the objective of the Organization.

## CHAPTER III - MEMBERSHIP AND ASSOCIATE MEMBERSHIP

### Article 3

Membership in the Organization shall be open to all States.

### Article 4

Members of the United Nations may become Members of the Organization by signing or otherwise accepting this Constitution in accordance with the provisions of Chapter XIX and in accordance with their constitutional processes.

### Article 5

The States whose Governments have been invited to send observers to the International Health Conference held in New York, 1946, may become Members by signing or otherwise accepting this Constitution in accordance with the provisions of Chapter XIX and in accordance with their constitutional processes provided that such signature or acceptance shall be completed before the first session of the Health Assembly.

### Article 6

Subject to the conditions of any agreement between the United Nations and the Organization, approved pursuant to Chapter XVI, States which do not become Members in accordance with Articles 4 and 5 may apply to become Members and shall be admitted as Members when their application has been approved by a simple majority vote of the Health Assembly.

### Article 7 1

If a Member fails to meet its financial obligations to the Organization or in other exceptional circumstances, the Health Assembly may, on such conditions as it thinks proper, suspend the voting privileges and services to which a Member is entitled. The Health Assembly shall have the authority to restore such voting privileges and services.

### Article 8

Territories or groups of territories which are not responsible for the conduct of their international relations may be admitted as Associate Members by the Health Assembly upon application made on behalf of such territory or group of territories by the Member or other authority having responsibility for their international relations. Representatives of Associate Members to the Health Assembly should be qualified by their technical competence in the held of health and should be chosen from the native population. The nature and extent of the rights and obligations of Associate Members shall be determined by the Health Assembly.

## CHAPTER IV - ORGANS

### Article 9

The work of the Organization shall be carried out by:

(a) The World Health Assembly (herein called the Health Assembly);
(b) The Executive Board (hereinafter called the Board);
(c) The Secretariat.

## CHAPTER V - THE WORLD HEALTH ASSEMBLY

### Article 10

The Health Assembly shall be composed of delegates representing Members.

Article 11

Each Member shall be represented by not more than three delegates, one of whom shall be designated by the Member as chief delegate. These delegates should be chosen from among persons most qualified by their technical competence in the field of health, preferably representing the national health administration of the Member.

Article 12

Alternates and advisers may accompany delegates.

Article 13

The Health Assembly shall meet in regular annual session and in such special sessions as may be necessary. Special sessions shall be convened at the request of the Board or of a majority of the Members.

Article 14

The Health Assembly, at each annual session, shall select the country or region in which the next annual session shall be held, the Board subsequently fixing the place. The Board shall determine the place where a special session shall be held.

Article 15

The Board, after consultation with the Secretary-General of the United Nations, shall determine the date of each annual and special session.

Article 16

The Health Assembly shall elect its President and other officers at the beginning of each annual session. They shall hold office until their successors are elected.

Article 17

The Health Assembly shall adopt its own rules of procedure.

Article 18

The functions of the Health Assembly shall be:

(a) to determine the policies of the Organization;

(b) to name the Members entitled to designate a person to serve on the Board;

(c) to appoint the Director-General;

(d) to review and approve reports and activities of the Board and of the Director-General and to instruct the Board in regard to matters upon which action, study, investigation or report may be considered desirable;

(e) to establish such committees as may be considered necessary for the work of the Organization;

(f) to supervise the financial policies of the Organization and to review and approve the budget;

(g) to instruct the Board and the Director-General to bring to the attention of Members and of international organizations, governmental or non-governmental, any matter with regard to health which the Health Assembly may consider appropriate;

(h) to invite any organization, international or national, governmental or non-governmental, which has responsibilities related to those of the Organization, to appoint representatives to participate, without right of vote, in its meetings or in those of the committees and conferences convened under its authority, on conditions prescribed by the Health Assembly; but in the case of national organizations, invitations shall be issued only with the consent of the Government concerned;
(i) to consider recommendations bearing on health made by the General Assembly, the Economic and Social Council, the Security Council or Trusteeship Council of the United Nations, and to report to them on the steps taken by the Organization to give effect to such recommendations;

(j) to report to the Economic and Social Council in accordance with any agreement between the Organization and the United Nations;

(k) to promote and conduct research in the field of health by the personnel of the Organization, by the establishment of its own institutions or by co-operation with official or non-official institutions of any Member with the consent of its Government;

(l) to establish such other institutions as it may consider desirable;

(m) to take any other appropriate action to further the objective of the Organization.

Article 19

The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.

Article 20

Each Member undertakes that it will, within eighteen months after the adoption by the Health Assembly of a convention or agreement, take action relative to the acceptance of such convention or agreement. Each Member shall notify the Director-General of the action taken, and if it does not accept such convention or agreement within the time limit, it will furnish a statement of the reasons for non-acceptance. In case of acceptance, each Member agrees to make an annual report to the Director-General in accordance with Chapter XIV.

Article 21

The Health Assembly shall have authority to adopt regulations concerning:

(a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;

(b) nomenclatures with respect to diseases, causes of death and public health practices;

(c) standards with respect to diagnostic procedures for international use;

(d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;

(e) advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.

Article 22

Regulations adopted pursuant to Article 21 shall come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice.

Article 23

The Health Assembly shall have authority to make recommendations to Members with respect to any matter within the competence of the Organization.

## CHAPTER VI - THE EXECUTIVE BOARD

Article 24

The Board shall consist of thirty-two persons designated by as many Members. The Health Assembly, taking into account an equitable geographical distribution, shall elect the Members entitled to designate a person to serve on the Board, provided that, of such Members, not less than three shall be elected from each of the regional organizations established pursuant to Article 44. Each of these Members should appoint to the Board a person technically qualified in the field of health, who may be accompanied by alternates and advisers.

Article 25

These Members shall be elected for three years and may be re-elected, provided that of the Members elected at the first session of the Health Assembly held after the coming into force of the amendment to this Constitution increasing the membership of the Board from thirty-one to thirty-two the term of office of the additional Member elected shall, insofar as may be necessary, be of such lesser duration as shall facilitate the election of at least one Member from each regional organization in each year.

Article 26

The Board shall meet at least twice a year and shall determine the place of each meeting.

Article 27

The Board shall elect its Chairman from among its members and shall adopt its own rules of procedure.

Article 28

The functions of the Board shall be:

(a) to give effect to the decisions and policies of the Health Assembly;

(b) to act as the executive organ of the Health Assembly;

(c) to perform any other functions entrusted to it by the Health Assembly;

(d) to advise the Health Assembly on questions referred to it by that body and on matters assigned to the Organization by conventions, agreements and regulations;

(e) to submit advice or proposals to the Health Assembly on its own initiative;

(f) to prepare the agenda of meetings of the Health Assembly;

(g) to submit to the Health Assembly for consideration and approval a general programme of work covering a specific period;

(h) to study all questions within its competence;

(i) to take emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate action. In particular it may authorize the Director-General to take the necessary steps to combat epidemics, to participate in the organization of health relief to victims of a calamity and to undertake studies and research the urgency of which has been drawn to the attention of the Board by any Member or by the Director-General.

Article 29

The Board shall exercise on behalf of the whole Health Assembly the powers delegated to it by that body.

## CHAPTER VII - THE SECRETARIAT

Article 30

The Secretariat shall comprise the Director-General and such technical and administrative staff as the Organization may require.

Article 31

The Director-General shall be appointed by the Health Assembly on the nomination of the Board on such terms as the Health Assembly may determine. The Director-General, subject to the authority of the Board, shall be the chief technical and administrative officer of the Organization.

Article 32

The Director-General shall be ex-officio Secretary of the Health Assembly, of the Board, of all commissions and committees of the Organization and of conferences convened by it. He may delegate these functions.

Article 33

The Director-General or his representative may establish a procedure by agreement with Members, permitting him, for the purpose of discharging his duties, to have direct access to their various departments, especially to their health administrations and to national health organizations, governmental or non-governmental. He may also establish direct relations with international organizations whose activities come within the competence of the Organization. He shall keep regional offices informed on all matters involving their respective areas.

Article 34

The Director-General shall prepare and submit to the Board the financial statements and budget estimates of the Organization.

Article 35

The Director-General shall appoint the staff of the Secretariat in accordance with staff regulations established by the Health Assembly. The paramount consideration in the employment of the staff shall be to assure that the efficiency, integrity and internationally representative character of the Secretariat shall be maintained at the highest level. Due regard shall be paid also to the importance of recruiting the staff on as wide a geographical basis as possible.

Article 36

The conditions of service of the staff of the Organization shall conform as far as possible with those of other United Nations organizations.

Article 37

In the performance of their duties the Director-General and the staff shall not seek or receive instructions from any government or from any authority external to the Organization. They shall refrain from any action which might reflect on their position as international officers. Each Member of the Organization on its part undertakes to respect the exclusively international character of the Director-General and the staff and not to seek to influence them.

## CHAPTER VIII - COMMITTEES

### Article 38

The Board shall establish such committees as the Health Assembly may direct and, on its own initiative or on the proposal of the Director-General, may establish any other committees considered desirable to serve any purpose within the competence of the Organization.

### Article 39

The Board, from time to time and in any event annually, shall review the necessity for continuing each committee.

### Article 40

The Board may provide for the creation of or the participation by the Organization in joint or mixed committees with other organizations and for the representation of the Organization in committees established by such other organizations.

## CHAPTER IX - CONFERENCES

### Article 41

The Health Assembly or the Board may convene local, general, technical or other special conferences to consider any matter within the competence of the Organization and may provide for the representation at such conferences of international organizations and, with the consent of the Government concerned, of national organizations, governmental or non-governmental. The manner of such representation shall be determined by the Health Assembly or the Board.

### Article 42

The Board may provide for representation of the Organization at conferences in which the Board considers that the Organization has an interest.

## CHAPTER X - HEADQUARTERS

### Article 43

The location of the headquarters of the Organization shall be determined by the Health Assembly after consultation with the United Nations.

## CHAPTER XI - REGIONAL ARRANGEMENTS

### Article 44

(a) The Health Assembly shall from time to time define the geographical areas in which it is desirable to establish a regional organization.

(b) The Health Assembly may, with the consent of a majority of the Members situated within each area so defined, establish a regional organization to meet the special needs of such area. There shall not be more than one regional organization in each area.

### Article 45

Each regional organization shall be an integral part of the Organization in accordance with this Constitution.

Article 46

Each regional organization shall consist of a regional committee and a regional office.

Article 47

Regional committees shall be composed of representatives of the Member States and Associate Members in the region concerned. Territories or groups of territories within the region, which are not responsible for the conduct of their international relations and which are not Associate Members, shall have the right to be represented and to participate in regional committees. The nature and extent of the rights and obligations of these territories or groups of territories in regional committees shall be determined by the Health Assembly in consultation with the Member or other authority having responsibility for the international relations of these territories and with the Member States in the region.

Article 48

Regional committees shall meet as often as necessary and shall determine the place of each meeting.

Article 49

Regional committees shall adopt their own rules of procedure.

Article 50

The functions of the regional committee shall be:

(a) to formulate policies governing matters of an exclusively regional character;

(b) to supervise the activities of the regional office;

(c) to suggest to the regional office the calling of technical conferences and such additional work or investigation in health matters as in the opinion of the regional committee would promote the objective of the Organization within the region;

(d) to co-operate with the respective regional committees of the United Nations and with those of other specialized agencies and with other regional international organizations having interests in common with the Organization;

(e) to tender advice, through the Director-General, to the Organization on international health matters which have wider than regional significance;

(f) to recommend additional regional appropriations by the Governments of the respective regions if the proportion of the central budget of the Organization allotted to that region is insufficient for the carrying-out of the regional functions;

(g) such other functions as may be delegated to the regional committee by the Health Assembly, the Board or the Director-General.

Article 51

Subject to the general authority of the Director-General of the Organization, the regional office shall be the administrative organ of the regional committee. It shall, in addition, carry out within the region the decisions of the Health Assembly and of the Board.

Article 52

The head of the regional office shall he the Regional Director appointed by the Board in agreement with the regional committee.

Article 53

The staff of the regional office shall be appointed in a manner to be determined by agreement between the Director-General and the Regional Director.

Article 54

The Pan American Sanitary Organization 1 represented by the Pan American Sanitary Bureau and the Pan American Sanitary Conferences, and all other intergovernmental regional health organizations in existence prior to the date of signature of this Constitution, shall in due course be integrated with the Organization. This integration shall be effected as soon as practicable through common action based on mutual consent of the competent authorities expressed through the organizations concerned.

## CHAPTER XII - BUDGET AND EXPENSES

Article 55

The Director-General shall prepare and submit to the Board the budget estimates of the Organization. The Board shall consider and submit to the Health Assembly such budget estimates, together with any recommendations the Board may deem advisable.

Article 56

Subject to any agreement between the Organization and the United Nations, the Health Assembly shall review and approve the budget estimates and shall apportion the expenses among the Members in accordance with a scale to be fixed by the Health Assembly.

Article 57

The Health Assembly or the Board acting on behalf of the Health Assembly may accept and administer gifts and bequests made to the Organization provided that the conditions attached to such gifts or bequests are acceptable to the Health Assembly or the Board and are consistent with the objective and policies of the Organization.

Article 58

A special fund to be used at the discretion of the Board shall be established to meet emergencies and unforeseen contingencies.

## CHAPTER XIII - VOTING

Article 59

Each Member shall have one vote in the Health Assembly.

Article 60

(a) Decisions of the Health Assembly on important questions shall be made by a two-thirds majority of the Members present and voting. These questions shall include: the adoption of conventions or agreements; the approval of agreements bringing the Organization into relation with the United Nations and intergovernmental organizations and agencies in accordance with Articles 69, 70 and 72; amendments to this Constitution.

(b) Decisions on other questions, including the determination of additional categories of questions to be decided by a two-thirds majority, shall be made by a majority of the Members present and voting.

(c) Voting on analogous matters in the Board and in committees of the Organization shall be made in accordance with paragraphs (a) and (b) of this Article.

## CHAPTER XIV - REPORTS SUBMITTED BY STATES

### Article 61

Each Member shall report annually to the Organization on the action taken and progress achieved in improving the health of its people.

### Article 62

Each Member shall report annually on the action taken with respect to recommendations made to it by the Organization and with respect to conventions, agreements and regulations.

### Article 63

Each Member shall communicate promptly to the Organization important laws, regulations, official reports and statistics pertaining to health which have been published in the State concerned.

### Article 64

Each Member shall provide statistical and epidemiological reports in a manner to be determined by the Health Assembly.

### Article 65

Each Member shall transmit upon the request of the Board such additional information pertaining to health as may be practicable.

## CHAPTER XV - LEGAL CAPACITY, PRIVILEGES AND IMMUNITIES

### Article 66

The Organization shall enjoy in the territory of each Member such legal capacity as may be necessary for the fulfilment of its objective and for the exercise of its functions.

### Article 67

(a) The Organization shall enjoy in the territory of each Member such privileges and immunities as may be necessary for the fulfilment of its objective and for the exercise of its functions.

(b) Representatives of Members, persons designated to serve on the Board and technical and administrative personnel of the Organization shall similarly enjoy such privileges and immunities as are necessary for the independent exercise of their functions in connexion with the Organization.

### Article 68

Such legal capacity, privileges and immunities shall be defined in a separate agreement to be prepared by the Organization in consultation with the Secretary-General of the United Nations and concluded between the Members.

## CHAPTER XVI - RELATIONS WITH OTHER ORGANIZATIONS

### Article 69

The Organization shall be brought into relation with the United Nations as one of the specialized agencies referred to in Article 57 of the Charter of the United Nations. The agreement or agreements bringing the Organization into relation with the United Nations shall be subject to approval by a two-thirds vote of the Health Assembly.

Article 70

The Organization shall establish effective relations and co-operate closely with such other inter-governmental organizations as may be desirable. Any formal agreement entered into with such organizations shall be subject to approval by a two-thirds vote of the Health Assembly.

Article 71

The Organization may, on matters within its competence, make suitable arrangements for consultation and co-operation with non-governmental international organizations and, with the consent of the Government concerned, with national organizations, governmental or non-governmental.

Article 72

Subject to the approval by a two-thirds vote of the Health Assembly, the Organization may take over from any other international organization or agency whose purpose and activities lie within the field of competence of the Organization such functions, resources and obligations as may be conferred upon the Organization by international agreement or by mutually acceptable arrangements entered into between the competent authorities of the respective organizations.

## CHAPTER XVII - AMENDMENTS

Article 73

Texts of proposed amendments to this Constitution shall be communicated by the Director-General to Members at least six months in advance of their consideration by the Health Assembly. Amendments shall come into force for all Members when adopted by a two-thirds vote of the Health Assembly and accepted by two-thirds of the Members in accordance with their respective constitutional processes.

## CHAPTER XVIII - INTERPRETATION

Article 74[1]

The Chinese, English, French, Russian and Spanish texts of this Constitution shall be regarded as equally authentic.

Article 75

Any question or dispute concerning the interpretation or application of this Constitution which is not settled by negotiation or by the Health Assembly shall be referred to the International Court of Justice in conformity with the Statute of the Court, unless the parties concerned agree on another mode of settlement.

Article 76

Upon authorization by the General Assembly of the United Nations or upon authorization in accordance with any agreement between the Organization and the United Nations, the Organization may request the International Court of Justice for an advisory opinion on any legal question arising within the competence of the Organization.

Article 77

The Director-General may appear before the Court on behalf of the Organization in connexion with any proceedings arising out of any such request for an advisory opinion. He shall make arrangements for the presentation of the case before the Court, including arrangements for the argument of different views on the question.

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[1] The amendment to this Article adopted by the Thirty-first World Health Assembly (resolution WHA31.18 has not yet come into force.

## CHAPTER XIX - ENTRY-INTO-FORCE

### Article 78

Subject to the provisions of Chapter III, this Constitution shall remain open to all States for signature or acceptance.

### Article 79

(a) States may become parties to this Constitution by:

(i) signature without reservation as to approval;

(ii) signature subject to approval followed by acceptance; or

(iii) acceptance.

(b) Acceptance shall be effected by the deposit of a formal instrument with the Secretary-General of the United Nations.

### Article 80

This Constitution shall come into force when twenty-six Members of the United Nations have become parties to it in accordance with the provisions of Article 79.

### Article 81

In accordance with Article 102 of the Charter of the United Nations, the Secretary-General of the United Nations will register this Constitution when it has been signed without reservation as to approval on behalf of one State or upon deposit of the first instrument of acceptance.

### Article 82

The Secretary-General of the United Nations will inform States parties to this Constitution of the date when it has come into force. He will also inform them of the dates when other States have become parties to this Constitution.

IN FAITH WHEREOF the undersigned representatives, having been duly authorized for that purpose, sign this Constitution.

DONE in the City of New York this twenty-second day of July 1946, in a single copy in the Chinese, English, French, Russian and Spanish languages, each text being equally authentic. The original texts shall be deposited in the archives of the United Nations. The Secretary-General of the United Nations will send certified copies to each of the Governments represented at the Conference.

**Annex II**

**The right to the highest attainable standard of health : . 11/08/2000. E/C.12/2000/4, CESCR General comment 14. (General Comments)**

COMMITTEE ON ECONOMIC, SOCIAL
AND CULTURAL RIGHTS
Twenty-second session
Geneva, 25 April-12 May 2000
Agenda item 3

SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF
THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL
AND CULTURAL RIGHTS

General Comment No. 14 (2000)

The right to the highest attainable standard of health
(article 12 of the International Covenant on Economic, Social and Cultural Rights)

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable. (1)

2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right". Additionally, the right to health is recognized, inter alia, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, (2) as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments. (3)

3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the

contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

6. With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.

## I. NORMATIVE CONTENT OF ARTICLE 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations.

8. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. (4) Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

*1) Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs. (5)

*2) Accessibility.* Health facilities, goods and services (6) have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. (7)

ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

iii) Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

iv) Information accessibility: accessibility includes the right to seek, receive and impart information and ideas (8) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

*3) Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

*4) Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs. (9)

Article 12.2 (a). The right to maternal, child and reproductive health

14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) (10) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, (11) emergency obstetric services and access to information, as well as to resources necessary to act on that information. (12)

Article 12.2 (b). The right to healthy natural and workplace environments

15. "The improvement of all aspects of environmental and industrial hygiene" (art. 12.2 (b)) comprises, inter alia, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health. (13) Furthermore, industrial hygiene refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment. (14) Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.

Article 12.2 (c). The right to prevention, treatment and control of diseases

16. "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States' individual and joint efforts to, inter alia, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control.

Article 12.2 (d). The right to health facilities, goods and services (15)

17. "The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

Article 12. Special topics of broad application

*Non-discrimination and equal treatment*

18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

19. With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. (16) Inappropriate health resource allocation can lead to discrimination

that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

*Gender perspective*

20. The Committee recommends that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.

*Women and the right to health*

21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

*Children and adolescents*

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness. (17) The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. (18) Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

23. States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

24. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

*Older persons*

25. With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

*Persons with disabilities*

26. The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

*Indigenous peoples*

27. In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, (19) the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health.

*Limitations*

28. Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

29. In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

## II. STATES PARTIES' OBLIGATIONS

### General legal obligations

30. While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health. (20)

31. The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that

States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12. (21)

32. As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources. (22)

33. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. (23) The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Specific legal obligations

34. In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. (24) In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

35. Obligations to protect include, inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services.

36. The obligation to fulfil requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood,

particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services. (25)

37. The obligation to fulfil (facilitate) requires States inter alia to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to fulfil (provide) a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to fulfil (promote) the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include:

(1) fostering recognition of factors favouring positive health results, e.g. research and provision of information;

(2) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups;

(3) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services;

(4) supporting people in making informed choices about their health.

International obligations

38. In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. (26)

39. To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required. (27) States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank,

and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.

40. States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure. In this regard, the Committee recalls its position, stated in General Comment No. 8, on the relationship between economic sanctions and respect for economic, social and cultural rights.

42. While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.

Core obligations

43. In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, (28) the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(1) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(2) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(3) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(4) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(5) To ensure equitable distribution of all health facilities, goods and services;

(6) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

44. The Committee also confirms that the following are obligations of comparable priority:

(1) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(2) To provide immunization against the major infectious diseases occurring in the community;

(3) To take measures to prevent, treat and control epidemic and endemic diseases;

(4) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(5) To provide appropriate training for health personnel, including education on health and human rights.

45. For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical" (29) which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

## III. VIOLATIONS

46. When the normative content of article 12 (Part I) is applied to the obligations of States parties (Part II), a dynamic process is set in motion which facilitates identification of violations of the right to health. The following paragraphs provide illustrations of violations of article 12.

47. In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12. This follows from article 12.1, which speaks of the highest attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each State party to take the necessary steps to the maximum of its available resources. A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.

48. Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health, outlined in paragraph 43 above, constitutes a violation of the right to health. Violations through acts of commission include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.

49. Violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through acts of omission include the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, the failure to have a national policy on occupational safety and health as well as occupational health services, and the failure to enforce relevant laws.

### Violations of the obligation to respect

50. Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.

Violations of the obligation to protect

51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

Violations of the obligation to fulfil

52. Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.

## IV. IMPLEMENTATION AT THE NATIONAL LEVEL

Framework legislation

53. The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.

54. The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.

55. The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.

56. States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and

the time-frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health, States parties should identify the factors and difficulties affecting implementation of their obligations.

Right to health indicators and benchmarks

57. National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

58. Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.

Remedies and accountability

59. Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. (30) All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

60. The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. (31) Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

61. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

62. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

## V. OBLIGATIONS OF ACTORS OTHER THAN STATES PARTIES

63. The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance, as is the function of UNICEF in relation to the right to health of children. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

64. Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, The International Labour Organization, the

United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organization and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes. When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided by all other actors. The adoption of a human rights-based approach by United Nations specialized agencies, programmes and bodies will greatly facilitate implementation of the right to health. In the course of its examination of States parties' reports, the Committee will also consider the role of health professional associations and other non-governmental organizations in relation to the States' obligations under article 12.

65. The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as non governmental organizations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.

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Adopted on 11 May 2000.

1. For example, the principle of non-discrimination in relation to health facilities, goods and services is legally enforceable in numerous national jurisdictions.

2. In its resolution 1989/11.

3. The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by the United Nations General Assembly in 1991 (resolution 46/119) and the Committee's General Comment No. 5 on persons with disabilities apply to persons with mental illness; the Programme of Action of the International Conference on Population and Development held at Cairo in 1994, as well as the Declaration and Programme for Action of the Fourth World Conference on Women held in Beijing in 1995 contain definitions of reproductive health and women's health, respectively.

4. Common article 3 of the Geneva Conventions for the protection of war victims (1949); Additional Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts, art. 75 (2) (a); Additional Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts, art. 4 (a).

5. See WHO Model List of Essential Drugs, revised December 1999, WHO Drug Information, vol. 13, No. 4, 1999.

6. Unless expressly provided otherwise, any reference in this General Comment to health facilities, goods and services includes the underlying determinants of health outlined in paras. 11 and 12 (a) of this General Comment.

7. See paras. 18 and 19 of this General Comment.

8. See article 19.2 of the International Covenant on Civil and Political Rights. This General Comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.

9. In the literature and practice concerning the right to health, three levels of health care are frequently referred to: primary health care typically deals with common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low

cost; secondary health care is provided in centres, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes in-patient care at comparatively higher cost; tertiary health care is provided in relatively few centres, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals and doctors and special equipment, and is often relatively expensive. Since forms of primary, secondary and tertiary health care frequently overlap and often interact, the use of this typology does not always provide sufficient distinguishing criteria to be helpful for assessing which levels of health care States parties must provide, and is therefore of limited assistance in relation to the normative understanding of article 12.
10. According to WHO, the stillbirth rate is no longer commonly used, infant and under-five mortality rates being measured instead.

11. Prenatal denotes existing or occurring before birth; perinatal refers to the period shortly before and after birth (in medical statistics the period begins with the completion of 28 weeks of gestation and is variously defined as ending one to four weeks after birth); neonatal, by contrast, covers the period pertaining to the first four weeks after birth; while post-natal denotes occurrence after birth. In this General Comment, the more generic terms pre- and post-natal are exclusively employed.

12. Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.

13. The Committee takes note, in this regard, of Principle 1 of the Stockholm Declaration of 1972 which states: "Man has the fundamental right to freedom, equality and adequate conditions of life, in an environment of a quality that permits a life of dignity and well-being", as well as of recent developments in international law, including General Assembly resolution 45/94 on the need to ensure a healthy environment for the well-being of individuals; Principle 1 of the Rio Declaration; and regional human rights instruments such as article 10 of the San Salvador Protocol to the American Convention on Human Rights.

14. ILO Convention No. 155, art. 4.2.

15. See para. 12 (b) and note 8 above.

16. For the core obligations, see paras. 43 and 44 of the present General Comments.

17. Article 24.1 of the Convention on the Rights of the Child.

18. See World Health Assembly resolution WHA47.10, 1994, entitled "Maternal and child health and family planning: traditional practices harmful to the health of women and children".

19. Recent emerging international norms relevant to indigenous peoples include the ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989); articles 29 (c) and (d) and 30 of the Convention on the Rights of the Child (1989); article 8 (j) of the Convention on Biological Diversity (1992), recommending that States respect, preserve and maintain knowledge, innovation and practices of indigenous communities; Agenda 21 of the United Nations Conference on Environment and Development (1992), in particular chapter 26; and Part I, paragraph 20, of the Vienna Declaration and Programme of Action (1993), stating that States should take concerted positive steps to ensure respect for all human rights of indigenous people, on the basis of non-discrimination. See also the preamble and article 3 of the United Nations Framework Convention on Climate Change (1992); and article 10 (2) (e) of the United Nations Convention to Combat Desertification in Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa (1994). During recent years an increasing number of States have changed their constitutions and introduced legislation recognizing specific rights of indigenous peoples.

20. See General Comment No. 13, para. 43.

21. See General Comment No. 3, para. 9; General Comment No. 13, para. 44.

22. See General Comment No. 3, para. 9; General Comment No. 13, para. 45.

23. According to General Comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to facilitate and an obligation to provide. In the present General Comment, the obligation to fulfil also incorporates an obligation to promote because of the critical importance of health promotion in the work of WHO and elsewhere.

24. General Assembly resolution 46/119 (1991).

25. Elements of such a policy are the identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; the provision of health information to workers and the provision, if needed, of adequate protective clothing and equipment; the enforcement of laws and regulations through adequate inspection; the requirement of notification of occupational accidents and diseases, the conduct of inquiries into serious accidents and diseases, and the production of annual statistics; the protection of workers and their representatives from disciplinary measures for actions properly taken by them in conformity with such a policy; and the provision of occupational health services with essentially preventive functions. See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161).

26. Article II, Alma-Ata Declaration, Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, in: World Health Organization, "Health for All" Series, No. 1, WHO, Geneva, 1978.

27. See para. 45 of this General Comment.

28. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex, chaps. VII and VIII.

29. Covenant, art. 2.1.

30. Regardless of whether groups as such can seek remedies as distinct holders of rights, States parties are bound by both the collective and individual dimensions of article 12. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.

31. See General Comment No. 2, para. 9.

**Annex III**

## Treaty One[1] – The Right to Health and the Obligation to Respect the Right[2]

***Preamble***

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living with dignity. The realisation of the Right to Health may be pursued through numerous, complementary approaches, such as the formulation of health policies by various organisations, the implementation of health programmes developed by the World Health Organisation (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components that are legally enforceable.

2. The Human Right to Health is recognised in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the most comprehensive article on the Right to Health in international human rights law. As provided in article 12.1 of the ICESCR, States parties recognise "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realisation of this right". Additionally, the Right to Health is recognised, inter alia, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognise the Right to Health. These include the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the Commission on Human Rights, as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments has proclaimed the Right to Health.

3. The Right to Health is closely related to and dependent upon the realisation of other human rights, as contained in the International Bill of Rights. These include the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

4. Health is a dynamic state of complete physical, mental, spiritual and social well being and not merely the absence of disease or infirmity. The Right to Health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. It is understood that, for millions of people throughout the world, the full enjoyment of the Right to Health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. It is recognised that there are formidable structural and other obstacles resulting from international and more localised factors beyond the control of states that impede the full realisation of the Right to Health in many states.

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[1] This is to be the first of a three part series of treaties, which together would establish a Framework Convention system on the Right to Health as outlined in chapter 8E (3).

[2] This draft version of a Framework Treaty on the Right to Health and the Obligation to Respect the Right is firmly rooted in the General Comment on the Right to Health adopted by the Committee on Economic, Social and Cultural Rights and reproduced in Annex II. Indeed, some paragraphs have been transposed verbatim.

6. With the goal of establishing the importance of the Right to Health throughout the world this treaty is to be the first of three inter-connected treaties establishing the Right to Health. This first treaty establishes the framework for developing the Right to Health and focuses on outlining the obligation to respect this right. The second treaty will set out the obligation to protect the Right to Health and the third treaty will establish the obligations necessary to fulfil the Right to Health.

7. This treaty consists of five parts. They are:
(a) the normative content of the Right to Health (Part I), (b) the legal obligations on various parties to respect the Right to Health (Part II), (c) violations (Part III); (d) the establishment of the system to begin the process of broad consultation on the Right to Health (Part IV) and (e) the adoption procedure for this treaty to come into force (Part V).

## I. *Normative Content of the Right to Health*

8. The Right to Health is not to be understood as a right to be healthy. The Right to Health contains both freedoms and entitlements.

9.The freedoms include:

(a) The right to control one's health and body, including sexual and reproductive freedom, and

(b) The right to be free from interference with one's health, such as the right to be free from torture, non-consensual medical treatment and experimentation.

10. The entitlements include:

(a) The right to health education of individuals and communities through local, regional and international agencies. This education shall provide information to enable the individual and community to attain maximal health status.

(b) The right to a system of human flourishing that provides equality of opportunity for people, individually and collectively as a community, to enjoy the highest attainable level of health;

(c) The right to a system of health protection that includes mechanisms for individuals and communities to obtain redress for violations of the Right to Health.

11. The Right to Health is an inclusive right extending not only to timely and appropriate health care, but also embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including information dealing with sexual and reproductive health. A further key aspect of the Right to Health is the participation of the general population in all health-related decision-making at the community, national and international levels.

12. The Right to Health, like all human rights, imposes three types or levels of obligations on parties: the obligations to respect the Right to Health, protect the Right to Health and fulfil the Right to Health. In turn, the obligation to fulfil the Right to Health contains obligations to facilitate, provide and promote the right. The obligation to respect the Right to Health requires states or other entities to refrain from interfering directly or indirectly with the enjoyment of the Right to Health. The obligation to protect the Right to Health requires states or other entities to take measures that prevent third parties from interfering with the enjoyment of the right to health. Finally, the obligation to fulfil requires the adoption of appropriate legislative, administrative, budgetary, judicial, promotional and other measures directed toward achievement of the full realisation of the Right to Health by all parties.

13. The Right to Health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in the particular state party:

*a) Availability.*
Functioning public health and health-care facilities, goods and services, and health-related programmes have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They shall include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

*b) Accessibility.*
Health facilities, goods and services shall be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

iii) Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

iv) Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

*c) Acceptability.*
All health facilities, goods and services must be respectful of medical ethics and be culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

*d) Quality.*
All health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and non-expired drugs, scientifically approved and safe hospital equipment, safe and potable water and adequate sanitation.

14. This treaty proscribes any discrimination in access to health care and underlying determinants of health, as well as discrimination in access to the means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the Right to Health. It should be recognised that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. Even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

### II. *Obligation to Respect the Right to Health*

15. The constraints due to the limits of available resources are acknowledged but the obligation to *respect* the Right to Health imposes certain obligations that are effective immediately.

16. The obligation to *respect* the Right to Health requires states and other entities to avoid measures that hinder or prevent the enjoyment of the Right to Health.

17. The obligation to *respect* the Right to Health is more onerous in relation to vulnerable sections of the community such as children and adolescents, women, older persons, persons with disabilities and indigenous peoples.

#### State parties

18. States are under the obligation to respect the Right to Health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs.

19. Obligations to respect the Right to Health include a state's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases shall be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

20. States shall refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters.

21. States shall refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

22.The formulation and implementation of national health strategies and plans of action by states shall respect, *inter alia*, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes that may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under this treaty. Promoting health must involve effective community action in setting

priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if individual's participation is secured by states.

23.States shall recognise the essential role of international co-operation and comply with their commitment to take joint and separate action to achieve the full realisation of the Right to Health.

24. To comply with their international obligations in respecting the Right to Health, states shall respect the enjoyment of the Right to Health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law.

25. States shall refrain, at all times, from imposing embargoes or similar measures restricting the supply to another state of adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure.

**International Organisations**

26. Co-ordinated efforts for the realisation of the Right to Health shall be maintained by international organisations to enhance the interaction among all the actors concerned, including the various components of civil society. The WHO, the International Labour Organisation, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organisation and other relevant bodies within the United Nations system, shall co-operate effectively with States parties, building on their respective expertise, in relation to the implementation of the Right to Health at the national level, with due respect to their individual mandates.

27. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, shall pay greater attention to the protection of the Right to Health in their lending policies, credit agreements and structural adjustment programmes.

28. The adoption of a human rights-based approach by United Nations specialised agencies, programmes and bodies will greatly facilitate implementation of the Right to Health.

29. United Nations specialised agencies are under an obligation to ensure any policy relating to health is in conformity with the agency's obligations under the Right to Health and to work with local communities to enhance their health status.

**Multinational Organisations**

30. Multinational organisations must recognise the Right to Health and the obligation on them to respect the Right to Health in relation to their policies concerning states, communities and individuals. Multinational organisations' responsibility to respect the Right to Health includes the obligation to monitor their policies to limit any negative impact on health and to work with local communities to obviate any such effect. Multinational organisations must also determine ways to ensure that the health implications of their policy are positive. Where possible multinational organisations should also provide mechanisms for public debate and a have a complaint procedure to address issues in relation to their obligations under the Right to Health.

**Non-Governmental Organisations**

31. Non-governmental organisations have an obligation to recognise and respect the Right to Health. This obligation, in particular, includes ensuring that their policy implementation considers health implications and is in conformity with the Right to Health.

32. Non-governmental organisations must also use their position in the local community to facilitate the participation of alternative voices in the decision-making process within the local community regarding health.

**Communities**

33. Communities shall ensure that the Right to Health is an integral component of any policy, programme or strategy developed to discharge governmental obligations in relation to health.

34. Communities shall ensure effective systems exists to enable valuable community participation in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health.

35. Communities shall ensure respect for the individual's Right to Health by utilising the available mechanisms for redress when a violation of the Right to Health has occurred.

**Individuals**

36. The obligation on the individual with respect to the Right to Health is to respect the rights of others and to refrain from acts that would negatively impact on the health of others.

## III. *Violations*

37. Violations of the obligation to respect the Right to Health are those actions, policies or laws that contravene the normative standards set out above and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Violations of the Right to Health can occur through the direct action of states or other entities insufficiently regulated by the state. Violations through acts of commission include the formal repeal or suspension of legislation necessary for the continued enjoyment of the Right to Health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the Right to Health.

38. Violations of the obligation to respect the Right to Health can also occur through the omission or failure of states and other entities to take necessary measures arising from legal obligations. Violations through acts of omission include the failure to take appropriate steps towards the full realisation of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, and the failure to enforce relevant laws or repeal laws that adversely impact on the Right to Health.

39. Examples of violations of the obligation to respect the Right to Health include:

The failure to explicitly recognise and respect the Right to Health;

The denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination;

The deliberate withholding or misrepresentation of information vital to health protection or treatment;

The suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the Right to Health;

The failure of the international organisations, states, non-governmental organisations or multinational corporations to take into account their legal obligations regarding the Right to

Health when entering into bilateral or multilateral agreements with other states, international organisations and other entities, such as multinational corporations;

The use of coercive measures to regulate population such as compulsory sterilisation or abortion or the imposition of criminal sanctions against contraception, voluntary sterilisation and abortion;

The use of legal, regulatory and social barriers to limit access to health information and care for adolescents and other vulnerable sections of the community;

The governmental application of policies and actions that use medicine and health professionals to inflict torture, physical and psychological abuse and death;

The use of legislative or policy support for medical or cultural practices that endanger health such as female circumcision;

The failure to discourage or prohibit sex selection as a basis for abortion; and

The interference with the provision of health services as a punitive political measure.

## IV. *Development of a Broad System of Consultation*

40. All states and international organisations concerned with health are under an obligation to begin a programme of education and provide information concerning the Right to Health, its meaning and significance as well as the process of consultation on health that is initiated by this treaty.

41. The World Health Organisation is designated as the body charged with the role of establishing the broad system of consultation on the Right to Health. The WHO shall use its decentralised structure to ensure that the consultation process includes all relevant bodies concerned with health or that impact on health. This shall include international organisations, multinational corporations, states, international and national non-governmental organisations, communities and individuals.

42. The consultation process shall be particularly concerned with establishing the appropriate approach to achieve the promotion and fulfilment of the Right to Health. The material collected shall to be correlated and used to form the basis of the subsequent treaties in this series. The drafting of the second treaty in this series, the Right to Health and the Obligation to Protect, shall begin no more than ten years after the adoption of this treaty and the drafting of the third treaty, the Right to Health and the Obligation to Fulfil the Right, in no more than five years from the adoption of the Right to Health and the Obligation to Protect treaty.

## V. *Entry into force of this treaty*

43(a) International Organisations, States, Multinational Corporations and Non-Governmental Organisations can become parties to this treaty by:

(i) signature without reservation as to approval;

(ii) signature subject to approval followed by acceptance; or

(iii) acceptance.

(b) Acceptance shall be effected by the deposit of a formal instrument with the Secretary-General of the United Nations.

44. This Treaty shall come into force when twenty-six states and five other entities have become parties to it in accordance with the provisions of Article 43.

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